

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3501				BALTIMORE CITY HEALTH DEPT.		REGISTERED NO. 65 3501	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>ELIZABETH THOMPSON</b>				2. DATE AND HOUR OF DEATH <b>4-1-65 2:25 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MERCY HOSPITAL</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>14-01</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>1719 BOLTON ST</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>3-7-1890</b>	9. AGE (In years last birthday) <b>74 1/2</b>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>JOHNSTOWN, PENNA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CALBERT RATLIFF</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>SAMUEL THOMPSON</b>		ADDRESS <b>1719 BOLTON STREET</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>ASCVD - HYPERTENSION</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ARTICULAR NEPHROSCLEROSIS, DIABETES MELLITUS</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <del>if</del> (this hospital) attended the deceased from <b>3-11-1965</b> to <b>4-1-1965</b> , that <del>if</del> (we) last saw the deceased alive on <b>3-31-1965</b> and that <del>in my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>if</del> (We) <del>did</del> (did not) view the body after death.							
23A. SIGNATURE <b>Salvatore R. Donohue</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-1-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>SALVATORE R. DONOHUE</b>				23D. ADDRESS <b>MERCY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>RURIAL</b>		24B. DATE <b>4/3/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>BARBERSVILLE</b>		24D. LOCATION (City, town, or county) (State) <b>BARBERSVILLE, W. VA.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltner</b>		25C. FUNERAL DIRECTOR <b>H. W. MEARS &amp; SON</b>		ADDRESS <b>805 N. CALVERT ST.</b>	





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BIRTH NO. 65 3502		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3502	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Oris W. Barnett		2. DATE AND HOUR OF DEATH March 31 1965 10:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Church Home and Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Balto. County C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore Dundalk 21222 D. STREET ADDRESS (If rural, give location) 3139 Baybriar Road, 21222			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4/19/00	9. AGE (In years last birthday) 64	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steelworker		10B. KIND OF BUSINESS OR INDUSTRY Armco Steel		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME John Barnett		14. MOTHER'S MAIDEN NAME Anna Stanley	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No, Unknown) (If yes, give war or dates of service) Unknown WW II		16. SOCIAL SECURITY NO. 234 14 4980		17. INFORMANT As in # 4 Above Mora R. Barnett,	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Acute Myocardial Infarction (B) Atherosclerosis (C) Pulmonary Emphysema		INTERVAL BETWEEN ONSET AND DEATH 1 hr years years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from March 26 19 65 to March 31 19 65, that (1) (we) last saw the deceased alive on March 31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Howard Lutz		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3/31/65	
23C. PHYSICIAN'S NAME (Type) J. HOWARD LUTZ		M.D.		23D. ADDRESS Church Home Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/65		24C. NAME OF CEMETERY or CREMATORY Baltimore National	
24D. LOCATION Baltimore, Md		24E. NAME OF REGISTRAR W. Brooks Bradley		24F. ADDRESS Dundalk, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR W. Brooks Bradley		25C. FUNERAL DIRECTOR W. Brooks Bradley	

CHURCH - HOME

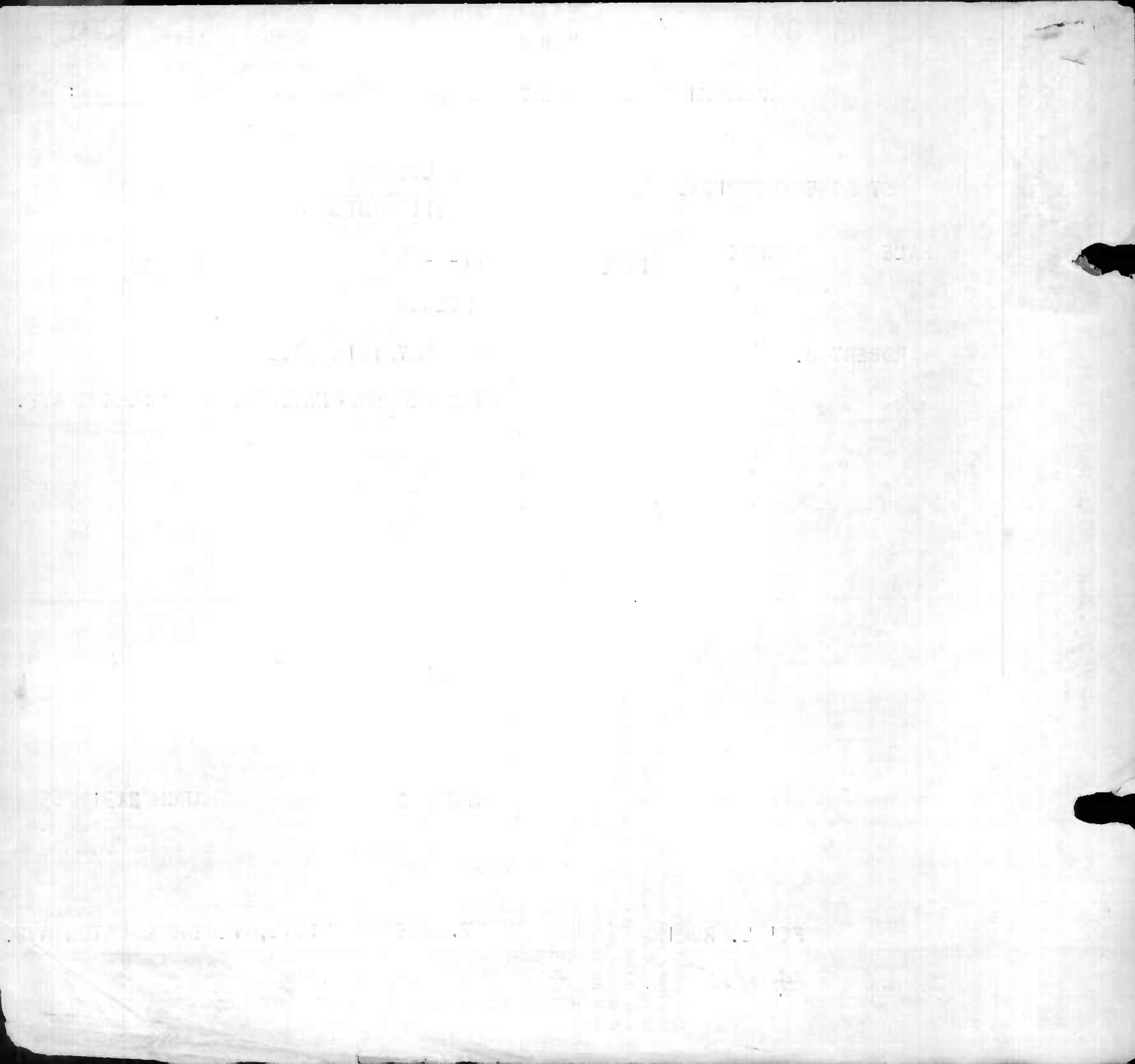
HOWARD LUTHER

HOWARD LUTHER

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BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 3503				
BIRTH NO. 65 3503		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KOKOSKI JR ROBERT JOHN		2. DATE AND HOUR OF DEATH MARCH 31, 1965 11:05A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL					A. STATE MD B. COUNTY Baltimore				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE					D. STREET ADDRESS (If rural, give location) 411 MONTEMAR AVE				
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH 11-3-64	9. AGE (In years last birthday) 4	10. Under 1 Yr. Months 4	11. Under 24 Hrs. Days 28	12. Hours	13. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ROBERT J.			14. MOTHER'S MAIDEN NAME PATRICIA BELL						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. None			17. INFORMANT ADDRESS ST AGNES HOSPITAL CATON & WILKENS AVE.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) Renal Failure				
ANTECEDENT CAUSES					(B) Congenital Renal Anomaly				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from MARCH 2 19 65 to MARCH 31 19 65, that (I) (we) last saw the deceased alive on MARCH 31 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Fe L. Rubin M.D.					23B. DATE SIGNED 3/31/65			23C. PHYSICIAN'S NAME (Type) FE L. RUBIN M.D.	
23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.									
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/1/65		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR Robert E. Farley, M.D.		25C. FUNERAL DIRECTOR ADDRESS Ambrose Inc. 1328 Sulphur Sp. Rd.					



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BIRTH NO. 65 3504		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3504	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLES MASSEY		2. DATE AND HOUR OF DEATH MARCH 30, 1965 10:50 P.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MARYLAND		B. COUNTY 4-02	
MONTEBELLO STATE HOSP.		D. STREET ADDRESS (If rural, give location)		102 N. WACA ST	
6. SEX M	7. RACE W	8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE	9. DATE OF BIRTH 6/30/00	10. AGE (In years last birthday) 64	11. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver		10B. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) GEORGIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN MASSEY		14. MOTHER'S MAIDEN NAME MARTHA TEAT	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) Not known		16. SOCIAL SECURITY NO. ?		17. INFORMANT Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO ARTERIOSCLEROSIS		± 4 yrs	
ANTECEDENT CAUSES		(B) DUE TO OB LITERANS of Leg		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Arteriosclerosis, gen.		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Dec. 4 1964 to March 30 1965, that (I) (we) last saw the deceased alive on March 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Reuben C. Guerrero M.D.		23B. DATE SIGNED 3/30/65		23C. PHYSICIAN'S NAME (Type) Reuben C. Guerrero M.D.	
23D. ADDRESS Montebello State Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 4/3/1965		24C. NAME OF CEMETERY OR CREMATORY Goshen Baptist Cemetery		24D. LOCATION (City, town, or county) (State) LINCOLN GA	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR Robert E. Entekuma		25C. FUNERAL DIRECTOR 8802 Harbord Blvd + Ruth H. H. H.	

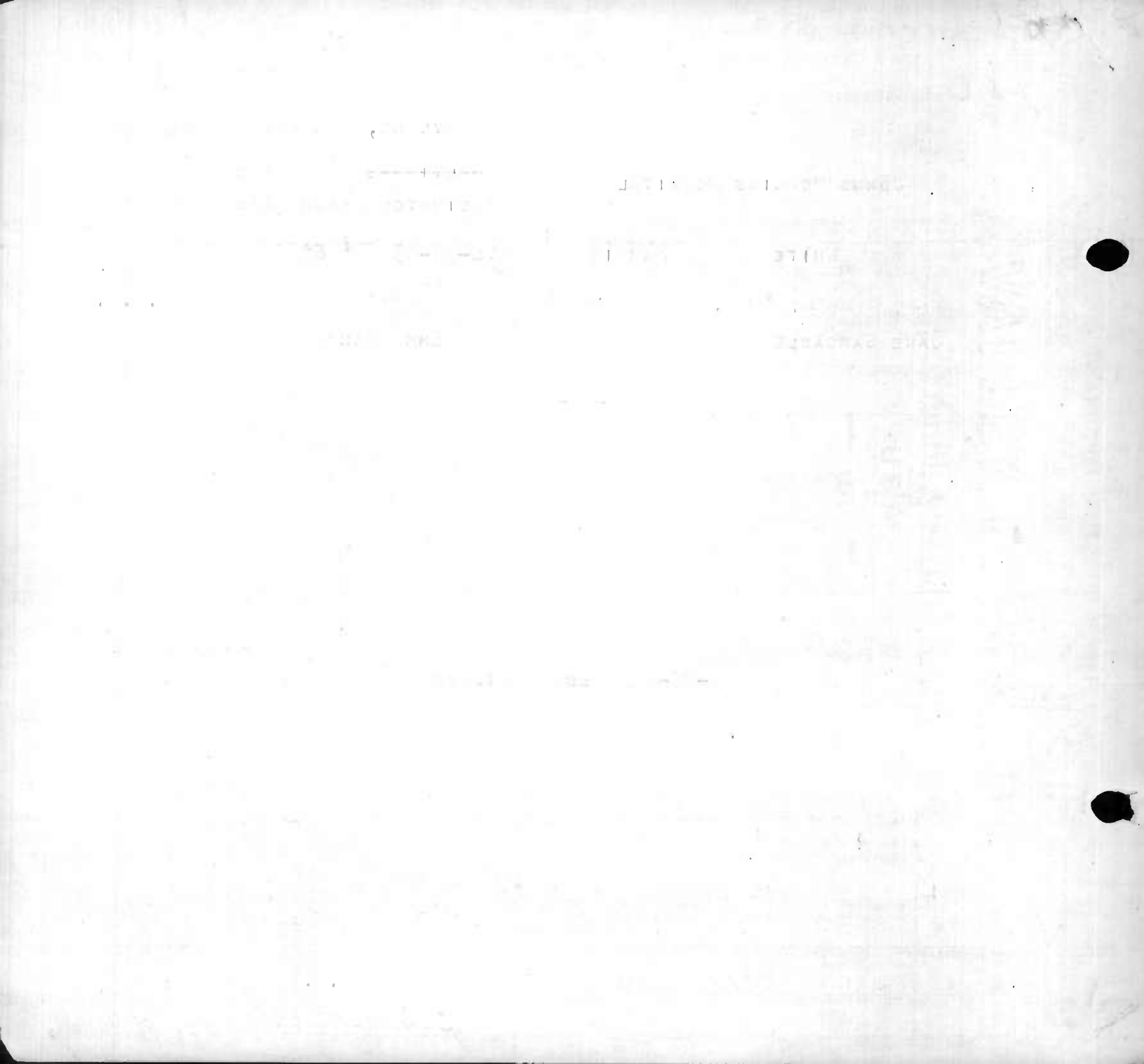


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BIRTH NO. 65 3505		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3505	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) SARGABLE, Charles Vernon	
2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
A. STATE		FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		B. COUNTY	
M. STATE		JOHNS HOPKINS HOSPITAL		MARYLAND, HARFORD	
C. CITY OR TOWN (If outside city limits, write RURAL and give township)		D. STREET ADDRESS (If rural, give location)		E. CITY OR TOWN	
Baltimore		ABINGTON BEACH ROAD		Harford	
Box 114				62-00	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
M	WHITE	MARRIED	8-31-03	61	U.S.A.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Heavy Equip. Oper.	Construction	Maryland	U.S.A.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
JAKE SARGABLE		EMMA BAKER		No	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
215-05-3885		Wife		Same as 4 c&d	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Pulmonary Hemorrhage	
ANTECEDENT CAUSES		(B) DUE TO		Lung abscess	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO		Pneumonia	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
3	3-21-65 LUNG ABSCESS	YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 2-12-19-65 to 3-25-19-65, that (I) (we) lost saw the deceased alive on 3-27-19-65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
H. Azar		3-27-65		H. AZAR	
23D. ADDRESS		23E. NAME OF REGISTRAR		23F. FUNERAL DIRECTOR	
Johns Hopkins Hospital		Robert E. Sargable		Tarring Funeral Home, Aberdeen, Md	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town, or county) (State)		
Burial	3/31/65	Smith Chapel Cemetery	R.D. Aberdeen, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR			
APR 2 1965	Robert E. Sargable	Tarring Funeral Home, Aberdeen, Md			

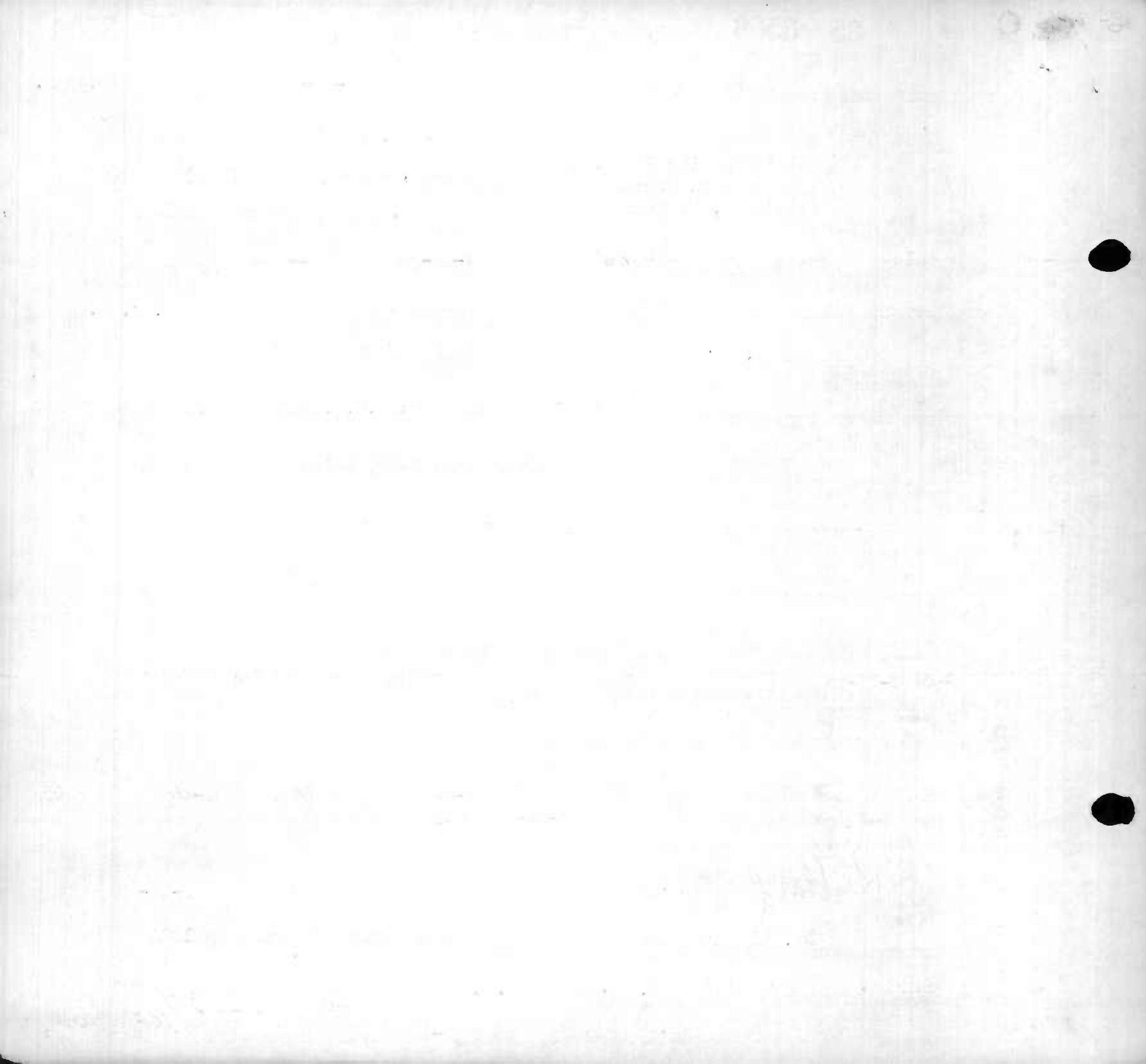




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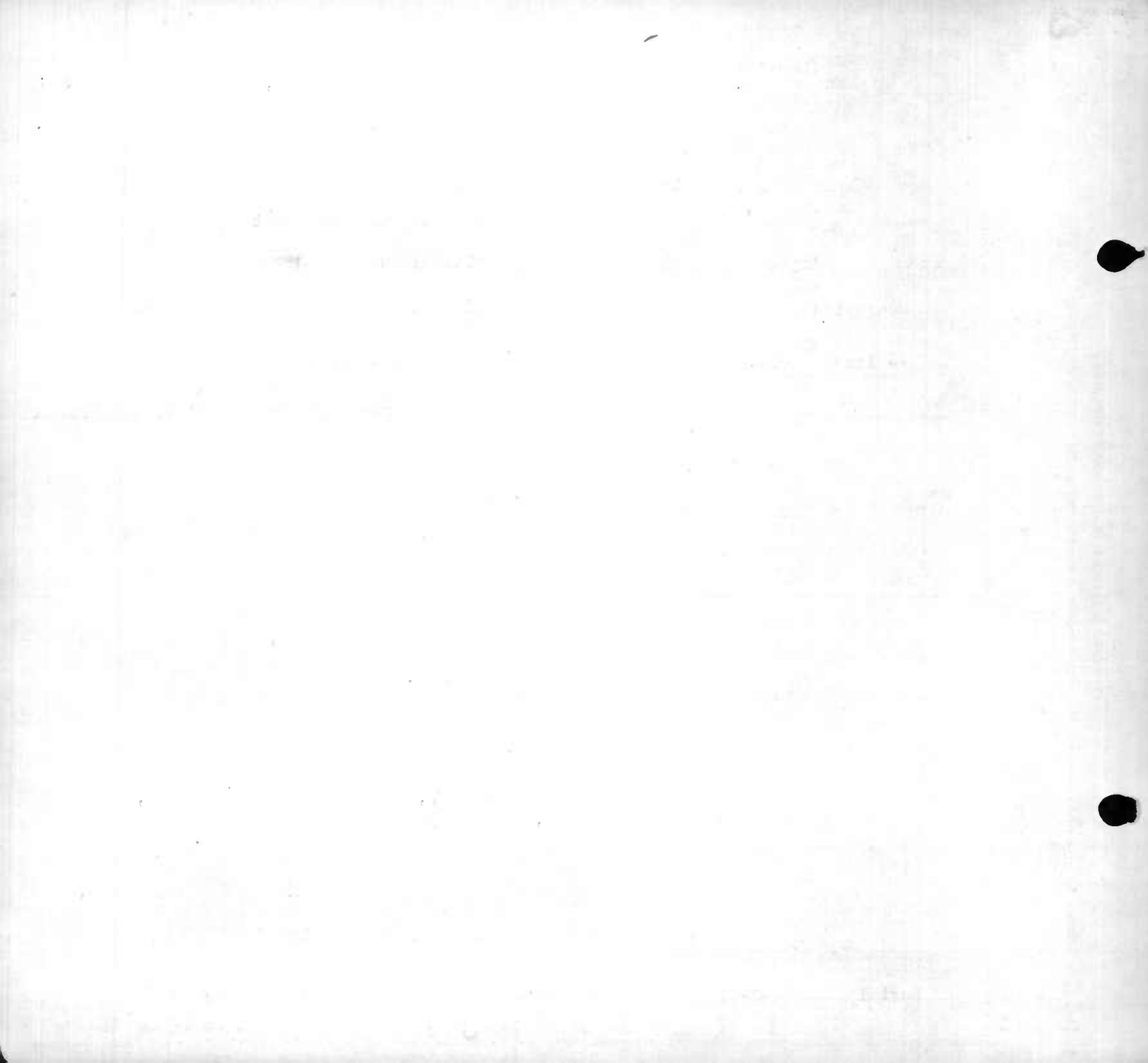
BIRTH NO. <b>65 3506</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 3506</b>	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>James Cooper</b>			3-26-65 10:15 A.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224</b>			A. STATE <b>Maryland, Baltimore</b> B. COUNTY <b>Balto</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Rural, Chase 63-00</b>		
			D. STREET ADDRESS (If rural, give location) <b>Box 35, Eastern Avenue #21027</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	B. DATE OF BIRTH <b>7-12-00</b>	9. AGE (In years last birthday) <b>64</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trackman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Joshua B. Cooper</b>			14. MOTHER'S MAIDEN NAME <b>Emmaline Quickley</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>717-07-5694</b>	17. INFORMANT ADDRESS <b>RECORDS: B.C.H. 4940 Eastern Avenue #21224</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Diverticulosis of Colon</b>			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3 3-25-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Same</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-24</b> 19 <b>65</b> to <b>3-26</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-26</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard Lane</b>				23B. DATE SIGNED <b>3-26-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Richard Lane</b>				23D. ADDRESS <b>4940 Eastern Avenue #21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>3/30/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary M.E. Cemetery</b>	
				24D. LOCATION (City, town, or county) (State) <b>Aberdeen, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stalder</b>		25C. FUNERAL DIRECTOR <b>John G. Tarring</b>	
				ADDRESS <b>Tarring Funeral Home, Aberdeen, Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

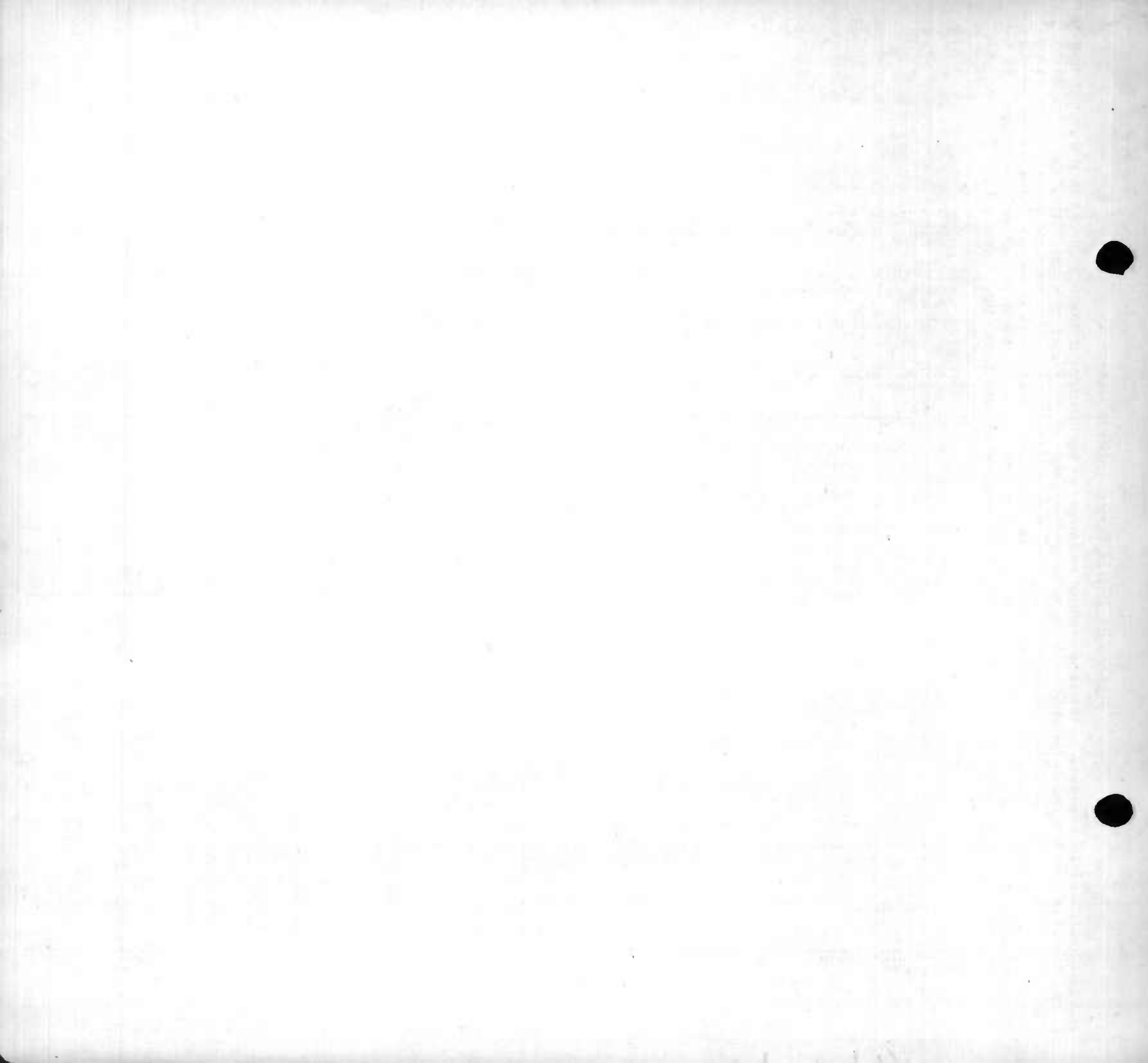
Baltimore City Health Department				Certificate of Death		Registered No. <u>65 3507</u>	
BIRTH NO. <u>65 3507</u>		M.E. CASE NO.		1. NAME OF DECEASED (Leavie) (Type or Print) <u>Lena Hamlett</u>		2. DATE AND HOUR OF DEATH <u>March 30, 1965</u> <u>1:20PM.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u> <u>1514 Division Street</u> <u>Baltimore, Maryland</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>1406 Mountmour Court</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	B. DATE OF BIRTH <u>1-18-1904</u>	9. AGE (In years lost birthday) <u>61</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Davis</u>				14. MOTHER'S MAIDEN NAME <u>Laura Wilson</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Corine Glasgow</u>		ADDRESS <u>1322 N. Caroline St</u>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>I</u> <u>Rupture of congenital aneurysm of left internal carotid artery</u> <u>Subarachnoid hemorrhage (small)</u>				INTERVAL BETWEEN ONSET AND DEATH			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <u>Pulmonary edema and hemorrhage, marked and bilateral</u>							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes.</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>March 27, 1965</u> to <u>March 30, 1965</u> , that (I) (we) last saw the deceased alive on <u>March 30, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ruperto Manankil</u>				23B. DATE SIGNED <u>March 30, 1965</u>			
23C. PHYSICIAN'S NAME (Type) <u>Ruperto Manankil</u>		23D. ADDRESS <u>1514 Division Street</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-2-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Haskins</u>		25C. FUNERAL DIRECTOR <u>MARSHALL W. JONES, JR.</u>		ADDRESS <u>1735 HARFORD AVE.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 3508</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 3508</b>	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>ANNA SOUSTER</b>		
2. DATE AND HOUR OF DEATH <b>3-30-65</b> <b>6 30 P.M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNIVERSITY HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>1420 CEDAR ST. BA</b>		
5. SEX <b>F</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>W</b>	8. DATE OF BIRTH <b>6-23-86</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>JAMES KRELICK</b>		
14. MOTHER'S MAIDEN NAME <b>BARBARA ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT <b>Family</b>		
18. ADDRESS <b>Same</b>					
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>INTERSCLOTTIC heart disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <b>?</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-26</b> <b>19 65</b> to <b>3-30</b> <b>19 65</b> , that (I) (we) last saw the deceased alive on <b>March 30</b> <b>19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Michael G. Hayes</b>				23B. DATE SIGNED <b>3-30-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Mich</b>				23D. ADDRESS M.D. <b>UNIVERSITY HOSP. UNIV. OF MD. BALTO. MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-2-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill Cem</b>	
24D. LOCATION <b>Balto Md</b>		24E. FUNERAL DIRECTOR <b>Mr. City</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Parker, M.D.</b>		25C. ADDRESS <b>237 Patuxent Ave</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3509		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3509	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) J. Newell Cox	
2. DATE AND HOUR OF DEATH 4-1-65 1 10 PM		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Pikesville 5300		D. STREET ADDRESS (If rural, give location) 722 HOWARD ROAD 8	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 2/15/98	9. AGE (In years last birthday) 67	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive		10B. KIND OF BUSINESS OR INDUSTRY ENGINEERING CO.		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thornton W. Cox		14. MOTHER'S MAIDEN NAME BERTHA Scharff	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS 20 East Franklin St. Mr. T. Newell Cox, Jr. Baltimore, Md. 21202	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO Acute Myocardial Infarction 1 Week			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO Arteriosclerotic Cardiovascular Disease			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No!	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from 3-26-1965 to 4-1-1965, that (we) last saw the deceased alive on 4-1-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Lawrence J. Lieberman, MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-1-65	
23C. PHYSICIAN'S NAME (Type) LAWRENCE J. LIBERMAN		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/3/65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge Cemetery Pikesville, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR Robert E. Talley		25C. FUNERAL DIRECTOR J. M. Ticken & Sons Baltimore, Md. 21217	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

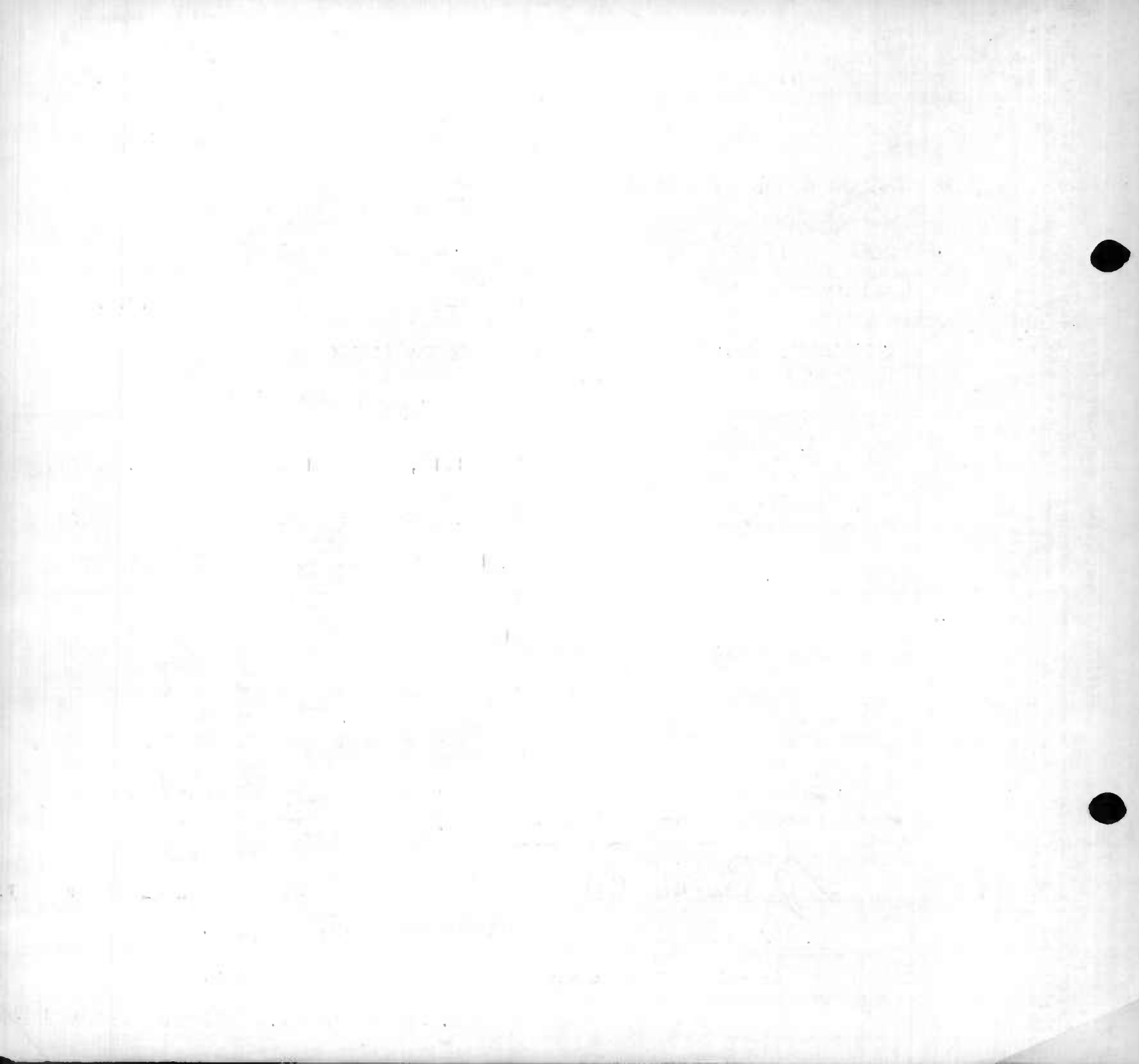
BIRTH NO. <u>65-02746</u> <u>65</u> <u>3510</u>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <u>65</u> <u>3510</u>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <u>Frazier, Baby Girl - Sarah</u>			2. DATE AND HOUR OF DEATH <u>February 6, 1965</u> <u>11:59 P.M.</u>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland - 21224</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>9-08</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2004 Robb Street - 21218</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>February 6, '65</u>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <u>2</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME		
14. MOTHER'S MAIDEN NAME <u>Frazier, Sarah</u>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT <u>Records - B.C.H.-4940 Eastern Avenue #21224</u>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Imaturity</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>February 6, 1965</u> to <u>February 6, 1965</u> , that (I) (we) last saw the deceased alive on <u>February 6, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>S. Wayne Klein</u> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <u>February 6, 1965</u>		
23C. PHYSICIAN'S NAME (Type) <u>Dr. S. Wayne Klein</u>			23D. ADDRESS <u>4940 Eastern Avenue - #21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremated</u>		24B. DATE <u>3-30-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore City Hospitals</u>	
24D. LOCATION <u>Baltimore, Maryland</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 2 1965</u>			
25A. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25B. FUNERAL DIRECTOR <u>3516</u>			

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3511				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 3511	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				NINA DOPP		3-31-65		11.30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY					
THE JOHNS HOPKINS HOSPITAL				VIRGINIA					
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)					
				FAIRFAX					
				D. STREET ADDRESS (If rural, give location)					
				25 OLD HICKORY ROAD, 4024					
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH		9. AGE (In years lost birthday)	
FEMALE		WHITE		MARRIED		3-23-23		42	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE						Louisiana		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
XXXXXXXXXXXX LEO EDWARDS				XXXXXXXXXXXX EDNA CAMPBELL BARNES					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
				433-28-4416		Earl W. DOPP, 4024 Old Hickory Road			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
				(A) ARTERITIS, GENERALIZED DUE TO				5 MONTHS	
ANTECEDENT CAUSES				(B) GANGRENE OF LEFT LOWER LEG DUE TO				1 MONTH	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) PERIPHERAL VASCULAR COLLAPSE				1 DAY	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				HEMOPTYSIS				3 DAYS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
0				NO					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (this hospital) attended the deceased from 26 MARCH 1965 to 31 March 1965, that (we) last saw the deceased alive on 31 MARCH 1965 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.									
23A. SIGNATURE				23B. DATE SIGNED					
L. J. Buckels M.D.				3-31-65					
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS					
L. J. BUCKELS				JOHNS HOPKINS HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		(State)	
REMOVAL		4-1-65		Epps Cemetery		Epps, Louisiana			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 2 1965		R. E. Taylor		Wm. Cook-Towson, Inc.,		1050 York Road, Towson			

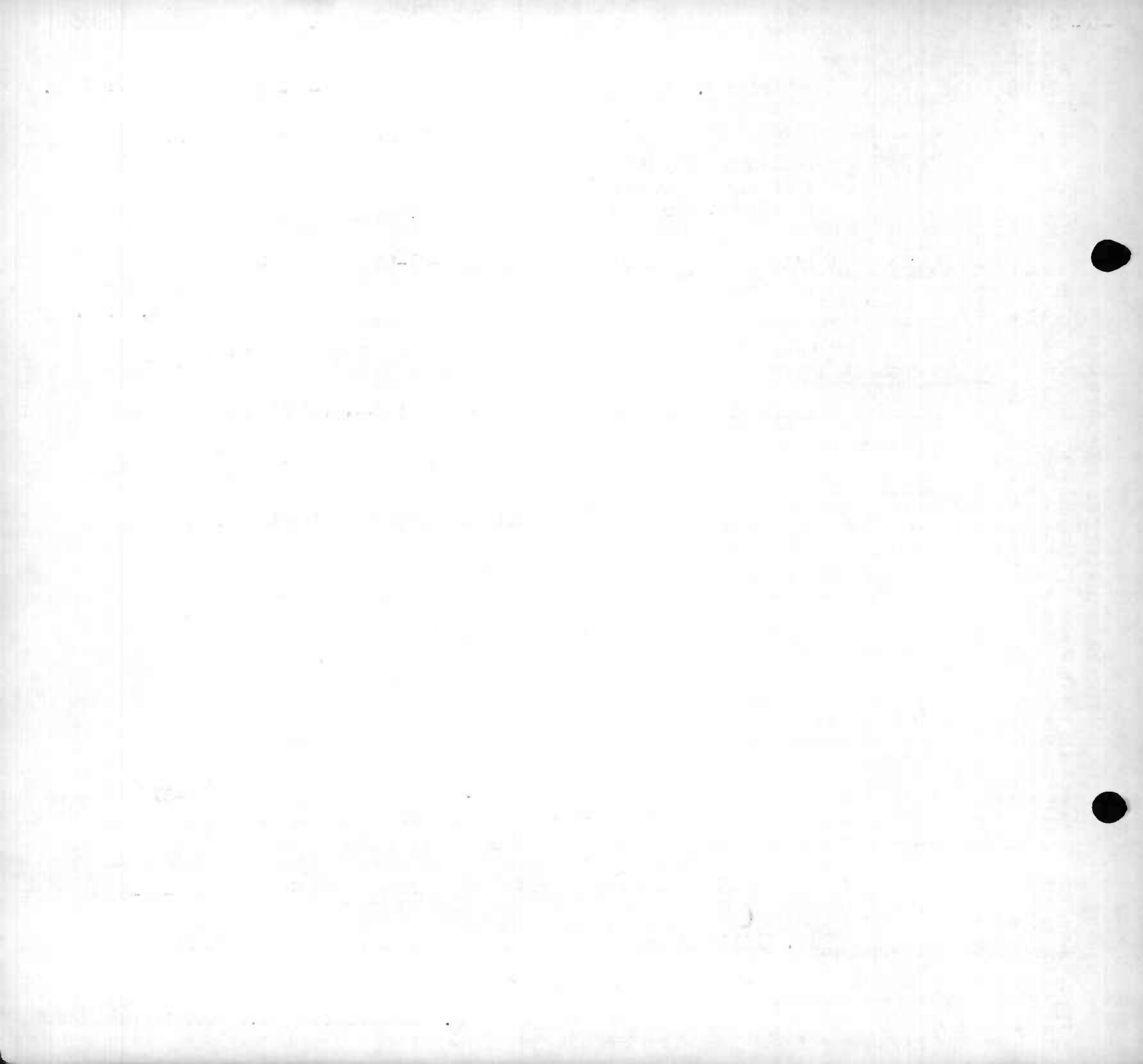


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				X	
65 3512				Registered No. 65 3512	
BIRTH NO.				M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR OF DEATH		
Helen E. Wilhelm			3-31-65 7:35 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224			A. STATE B. COUNTY Maryland, Baltimore		
5. SEX Female			6. RACE White		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married			8. DATE OF BIRTH 8-31-04		
9. AGE (In years last birthday) 60			10. CITIZEN OF WHAT COUNTRY? U. S. A.		
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME unknown			14. MOTHER'S MAIDEN NAME unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. none		
17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Staphylococcal Septicemia DUE TO (B) Cerebral Vascular Accident DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH 5 Days 2 Months					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Atrial Fibrillation					
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 3-16 19 65 to 3-31 19 65, that (I) (we) last saw the deceased alive on 3-31- 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Philip Zieve M.D.			23B. DATE SIGNED 3-31-65		
23C. PHYSICIAN'S NAME (Type) Dr. Philip Zieve			23D. ADDRESS 4940 Eastern Avenue #21224		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-3-65		24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery	
24D. LOCATION Baltimore		24E. DATE REC'D BY HEALTH DEPT. APR 2 1965			
24F. NAME OF REGISTRAR Robert E. Zieve		24G. FUNERAL DIRECTOR Wm. Cook-Hamilton, Inc., 6009 Harford Road			



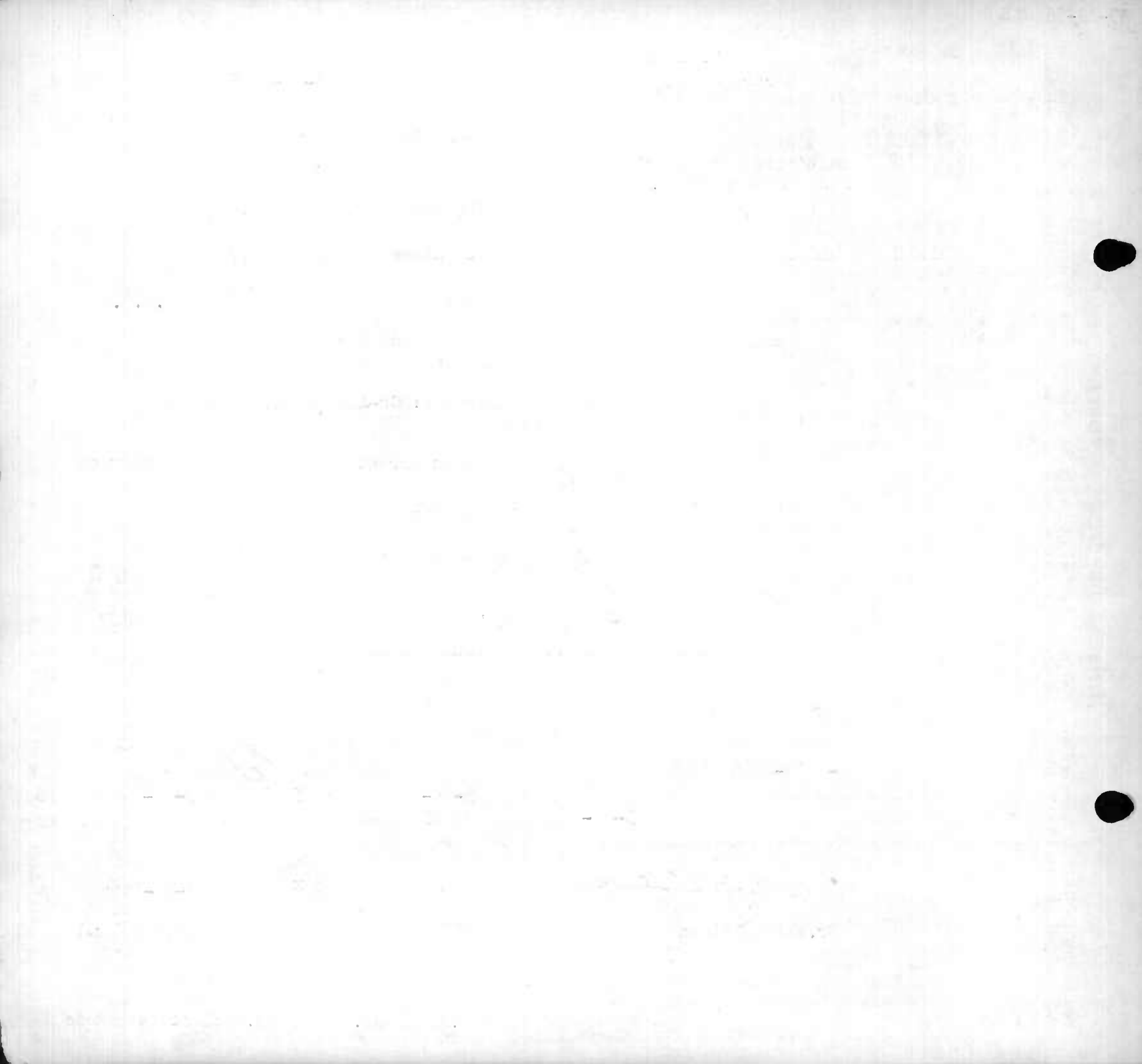


R-220  
F-200

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

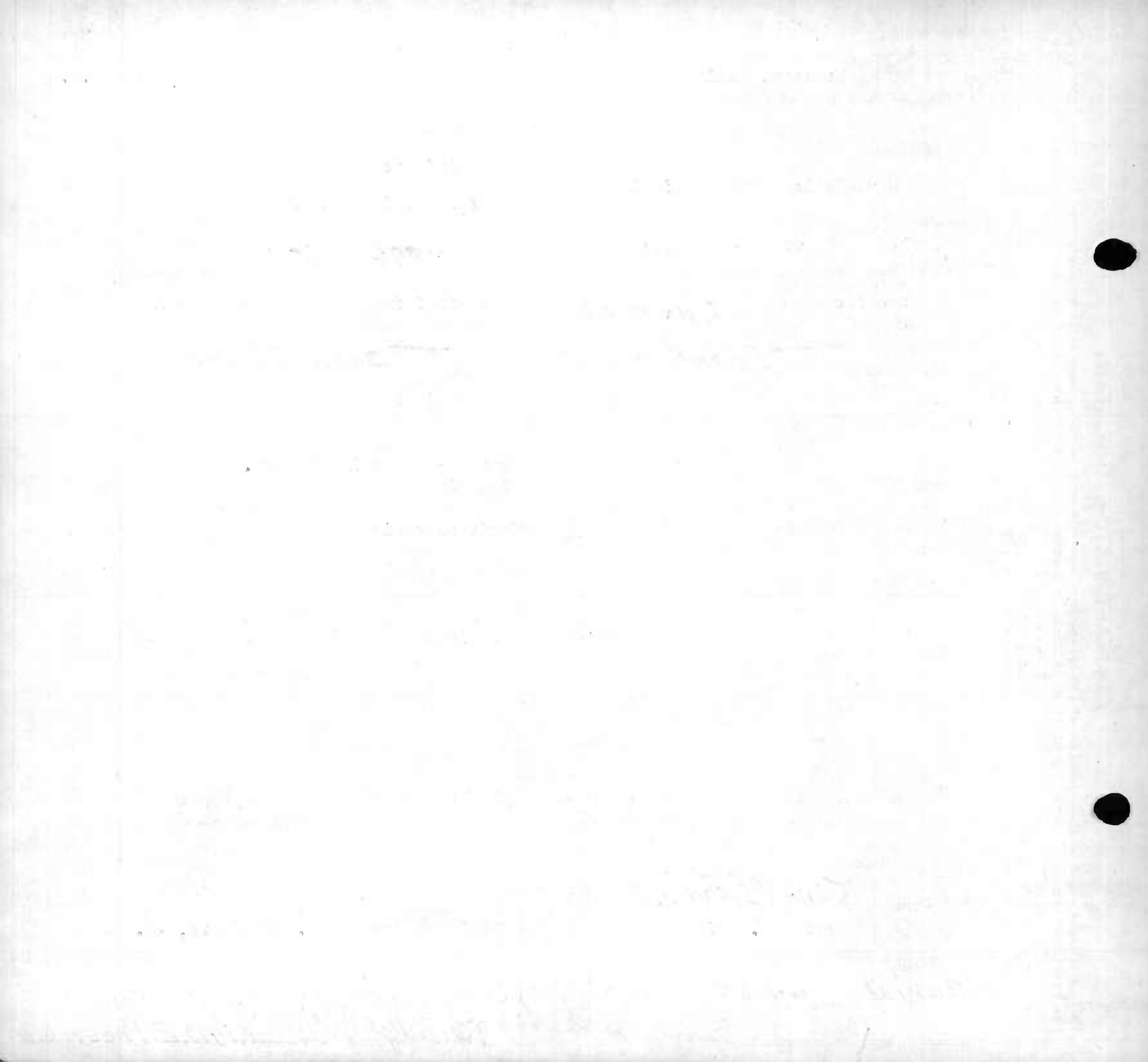
BIRTH NO. 65 3513				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3513	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) V. Reges Gertrude/Fox				2. DATE AND HOUR OF DEATH 3-28-1965 2 A M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY 26-08			
5. SEX FEMALE 6. RACE White 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed				8. DATE OF BIRTH 2-29-1889		9. AGE (In years lost birthday) 76 XXX	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME unknown			
14. MOTHER'S MAIDEN NAME unknown				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. M.D.				17. INFORMANT ADDRESS Records: BCH-4940 Eastern Avenue			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.) Cardiac Arrest				INTERVAL BETWEEN ONSET AND DEATH 4 minutes			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				20. CAUSE OF DEATH Renal Failure Hypotensive Episode			
21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fracture Left Hip				22. MEDICAL CERTIFICATION			
23A. DATE OF OPERATION		23B. CONDITION FOR WHICH OPERATION WAS PERFORMED		24A. AUTOPSY? (Yes or No) No		24B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
25A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		25C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) At patients home		25D. HOW DID INJURY OCCUR? Accident	
26A. TIME OF INJURY (APPROX.) 3-19-1965 11PM		26B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		26C. I certify that (I) (this hospital) attended the deceased from 3-20-19 65 to 3-28-19 65, and that (I) (we) last saw the deceased alive on 3-28-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		26D. DATE SIGNED 3-28-1965	
27A. SIGNATURE Dr. Philip Zieve		27B. PHYSICIAN'S NAME (Type) Dr. Philip Zieve		27C. ADDRESS 4940 Eastern Avenue, Baltimore, Maryland		27D. DATE SIGNED 3-28-1965	
28A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		28B. DATE 3-31-65		28C. NAME of CEMETERY or CREMATORY Oak Lawn Cemetery		28D. LOCATION (City, town, or county) (State) 7225 Eastern Avenue	
29A. DATE REC'D BY HEALTH DEPT. APR 2 1965		29B. NAME OF REGISTRAR Robert E. Taylor		29C. FUNERAL DIRECTOR Wm. C. Cook, Inc., 1217 St. Paul Street, Zone 2		29D. ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3514				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3514	
CERTIFICATE OF DEATH							
1. NAME OF DECEASED (Type or Print) <b>Hubbard, Dolla or Dollie Herbert</b>				2. DATE AND HOUR OF DEATH <b>3/28/65</b>		2:55 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Montebello State Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-12</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>4418 Howil Terrace</b>			
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED <b>Married</b>	8. DATE OF BIRTH <b>12/7/1896</b>		9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown Frank Mack</b>				14. MOTHER'S MAIDEN NAME <b>Mack Susie Brown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Diabetes Mellitus</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
				(A) <b>Cerebral thrombosis with rt. Hemiplegia</b>		<b>2 months</b>	
				(B) <b>Arteriosclerosis</b>		<b>Unknown</b>	
				(C)			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2/18/65</b> 19 to <b>3/28/65</b> 19, that (I) (we) last saw the deceased alive on <b>3/28/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Daniel G. Lai</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel G. Lai</b>				23D. ADDRESS M.D. <b>2201 Argonne Drive, Baltimore, Md. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-1-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery, Anne Arundel Co., Md.</b>		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stalder</b>		25C. FUNERAL DIRECTOR <b>Joseph J. Collick</b>		ADDRESS <b>1412 E. Preston St.</b>	



BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

ANNIE OR ANNA McLEAN

2. DATE AND HOUR PRONOUNCED DEAD

March 28, 1965

4:20 A.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

JOHNS HOPKINS HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

802 Shuter Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widowed

8. DATE OF BIRTH

12-26-1897

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

School

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

23484265

17. INFORMANT

Lillian McLean 802 Shuter St.

ADDRESS

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive and arteriosclerotic  
DUE TO cardiovascular disease

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Diabetes Mellitus

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
m. WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-28-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-1-65

23C. NAME OF CEMETERY or CREMATORY

Mr. Calvary Cemetery Anne Arundel Co. Va.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 2 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

R. Collick 1412 E. Preston St.

ADDRESS

WITNESSES

School

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION

EDUCATION



1  
5-530

65 3516

BALTIMORE CITY HEALTH DEPARTMENT

65 3516

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.		M.E. CASE NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
WILLIAM SMITH		3-28-65 4:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
ST. JOSPEH'S HOSPITAL - DOA		Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		1822 N. Spring Street 21205	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	Colored	Separated	7-30-1907
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
57		Sanitor	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Columbus, OHIO		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
David Smith		Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
yes		186-18-5463	
17. INFORMANT		ADDRESS	
Beatrice Turner		1222 N 5	
18. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			
Arteriosclerotic cardiovascular disease WITH ASPIRATION OF STOMACH CONTENT			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2		Yes	Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
PETER W. RIECKERT, M.D.		ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE	23C. NAME OF CEMETERY or CREMATORY
Burial		4-2-65	National Cemetery
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR
APR 2 1965		Robert E. Taylor, M.D.	Randolph J. Collick
		ADDRESS	
		1412 E. Presa	

DEPARTMENT

27

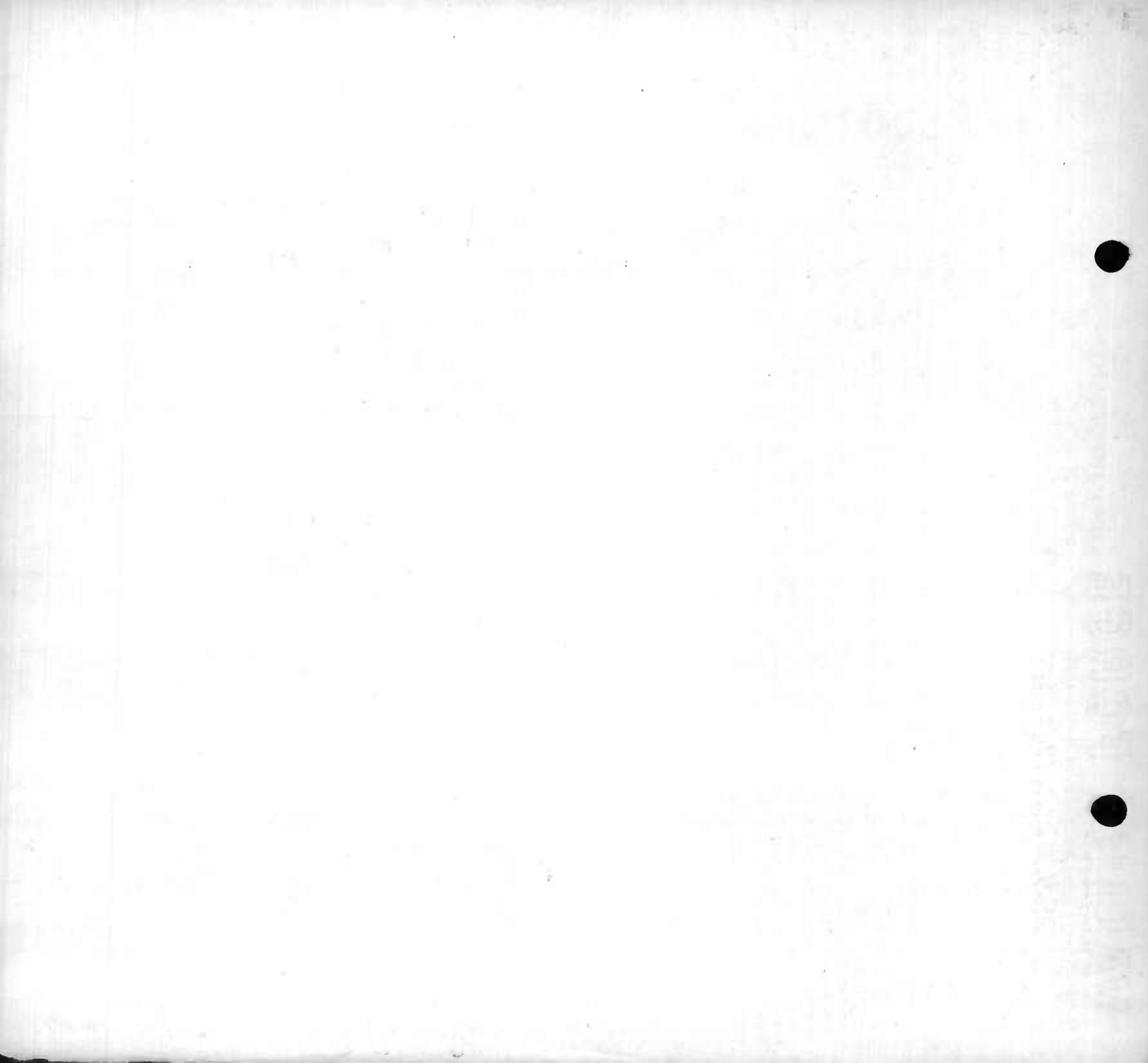
Beatrice Turner

Yes

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3517	
BIRTH NO. 65 3517		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) CHARLOTTE JESSUPS		2. DATE AND HOUR OF DEATH 3/31/65 12:12 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL		A. STATE Md. B. COUNTY 2007			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Balto.			
		D. STREET ADDRESS (If rural, give location) 132 N. Culver ST.			
5. SEX FEMALE	6. RACE NEGRO	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/10/15	9. AGE (in years last birthday) 49	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Balto. City School System		10B. KIND OF BUSINESS OR INDUSTRY Education		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Eugene E. Matthews		14. MOTHER'S MAIDEN NAME Mary Jones McLeod	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Osborn Jessups 132 Culver ST.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) DUE TO DIABETIC NEPHROPATHY & UREMIA			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO ANEMIA sec. to (A).			
		(C) DUE TO DIABETES MELLITUS.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/31 1965 to 3/31 1965, that (I) (we) last saw the deceased alive on 3/31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Oscar Ferdinandini M.D.				23B. DATE SIGNED 3/31/65	
23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI M.D.				23D. ADDRESS Lutheran Hosp.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-5-65		24C. NAME OF CEMETERY or CREMATORY Arbutus	
24D. LOCATION (City, town, or county) Arbutus		24E. LOCATION (State) Md.			
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS Morten & Dyett 916 PENNA. Ave.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3518	
BIRTH NO. 65 3518		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ARCHIE MC DOUGALD</b>		2. DATE AND HOUR OF DEATH <b>4-1-65</b>   <b>2:30PM</b> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE BALTO Co ZONE 19</b> D. STREET ADDRESS (If rural, give location) <b>2803 SPARROWS POINT RD. 53-00</b>			
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>DIVORCED</b>	8. DATE OF BIRTH <b>3-4-98</b>	9. AGE (In years lost birthday) <b>67</b>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Fayetteville, N.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>ARCHIE MC DOUGALD</b>		14. MOTHER'S MAIDEN NAME <b>KATHERINE</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-01-2783</b>		17. INFORMANT <b>A. McDougald</b> ADDRESS <b>2803 Sparrows Pt. #19</b>	
18. <b>527.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Cardiac Failure</b> DUE TO (B) <b>Cor Pulmonale</b> DUE TO (C) <b>Chronic Lung Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b> <b>?</b> <b>?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>1/22</b> 19 <b>65</b> to <b>4/1</b> 19 <b>65</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>4/1</b> 19 <b>65</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.					
23A. SIGNATURE <b>Michael Lesch</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <b>4/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL LESCH</b>		23D. ADDRESS M.D. <b>JOHNS HOPKINS HOSPITAL, BALTIMORE, MD</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-6-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION <b>A.A. Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>MORTON DGETT</b> ADDRESS <b>96 PENNA AVE.</b>			

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# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3519		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3519	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) Rosa Lee		
2. DATE AND HOUR OF DEATH March 30, 1965 1:38p M.					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division Street Baltimore, Maryland			A. STATE Maryland 8-03		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore		
			D. STREET ADDRESS (If rural, give location) 2441 E. Hoffman Street		
5. SEX Female	6. RACE Negro	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 9-19-11	9. AGE (In years last birthday) 53	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas Peoples			14. MOTHER'S MAIDEN NAME ALICE AVERY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS LAFAYETTE LEE 2441 E. Hoffman St		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) General Carcinomatosis DUE TO Carcinoma of ovary (B) DUE TO (C)		
18. INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-6-65 19 to 3-30-65 19, that (I) (we) last saw the deceased alive on 3-30-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Balbino Taya			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-30-65
23C. PHYSICIAN'S NAME (Type) Balbino Taya			23D. ADDRESS M.D. 1514 Division Street		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4/3/65	24C. NAME of CEMETERY or CREMATORY MT. CALVARY		24D. LOCATION (City, town, or county) (State) A.A. County Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Joseph B. Lockyer 1304 N. Central	

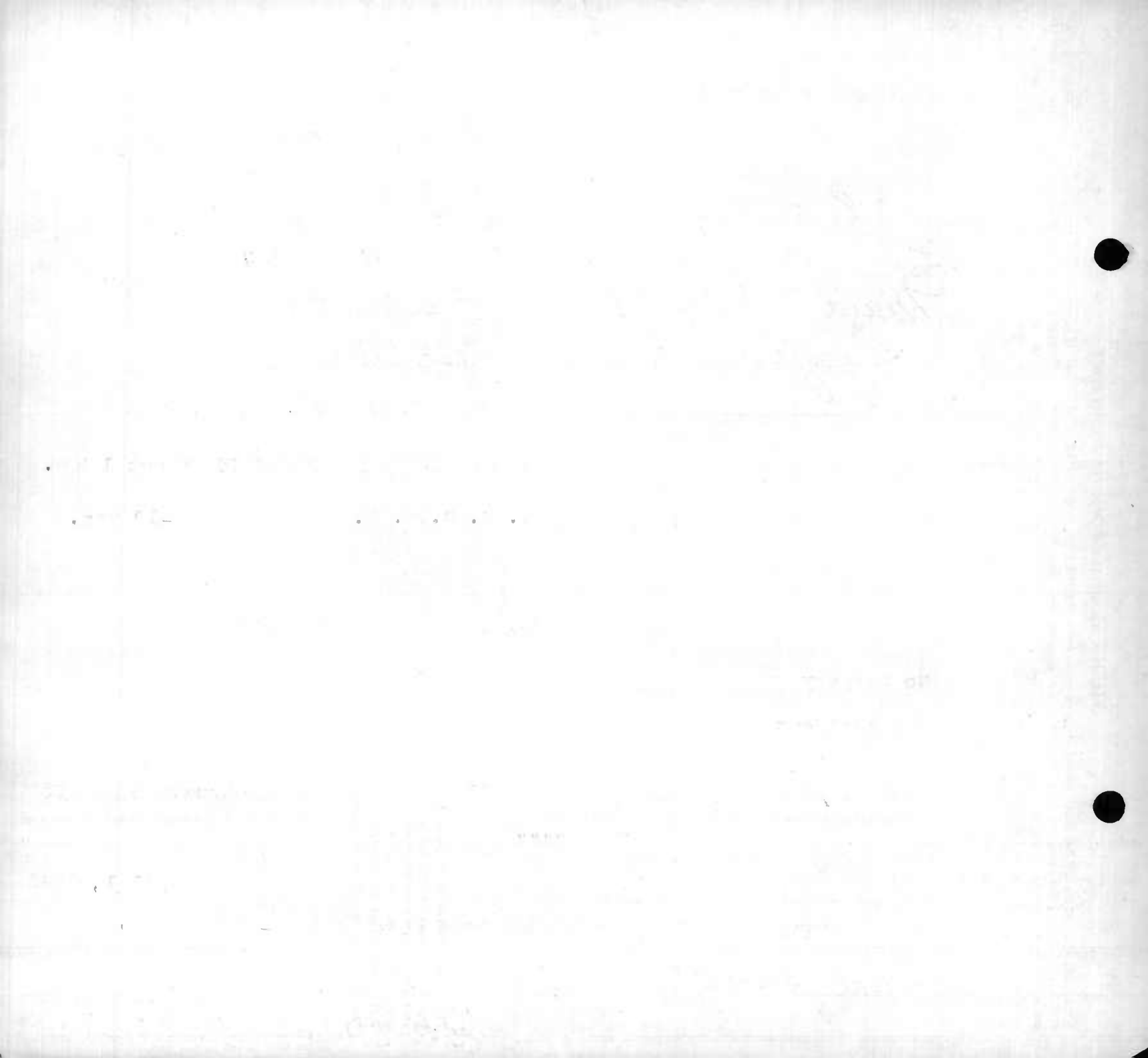




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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 3520</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 3520</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Helen Duvall</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Mar 28 - 1965</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">17-02</span>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">1218 Etting St</span>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1218 Etting St</span>	
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">col</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widow</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">7-13-1911</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">54</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Maid</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Dep Store</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore</span>	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <span style="font-size: 1.2em;">Benjiann Kerr</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Adeleide Brown</span>	
15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <span style="font-size: 1.2em;">Hannah Berry</span> ADDRESS <span style="font-size: 1.2em;">4727 Kember Rd</span>	
18. <span style="font-size: 1.2em;">420.1</span> I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)		(A) <span style="font-size: 1.2em;">ACUTE CORONARY THROMBOSIS</span> DUE TO		<span style="font-size: 1.2em;">about 1 hr.</span>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) <span style="font-size: 1.2em;">A. S. C. V. D.</span> DUE TO		<span style="font-size: 1.2em;">8-10 yrs.</span>	
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		None			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
<span style="font-size: 1.2em;">No surgery</span>				<span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">No accident</span>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">April 28</span> 19 <span style="font-size: 1.2em;">62</span> to <span style="font-size: 1.2em;">February 8</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">February 8</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Dr. Herman Seidel</span> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <span style="font-size: 1.2em;">April 1, 1965</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">HERMAN SEIDEL</span>				23D. ADDRESS <span style="font-size: 1.2em;">2404 BUTAW PLACE - BALTIMORE, MD</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4-2-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Mt Calvary Em</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Rid. Co. Md</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 2 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Raymond Sanders</span>		25D. ADDRESS <span style="font-size: 1.2em;">217 E Preston St</span>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3521		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3521	
M.E. CASE NO.			1. NAME OF DECEASED		
1. NAME OF DECEASED (Type or Print) MAUDE PARRON			2. DATE AND HOUR OF DEATH 4-1-1965 12:30 P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSP			A. STATE MD B. COUNTY 16-24		
5. SEX FEMALE			6. RACE Colored		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED			8. DATE OF BIRTH 12-7-1895		
9. AGE (In years lost birthday) 69			10. CITIZEN OF WHAT COUNTRY? USA		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC			11. BIRTHPLACE (State or foreign country) BALTIMORE		
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME CORNELIUS MONROE		
14. MOTHER'S MAIDEN NAME ANNIE PRETTYMAN			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS GORDON N. PARRON 807 N. PAYSON ST		
18. 442X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) DUE TO Myocardial insufficiency (B) DUE TO Hypertension & arteriosclerotic Cardio-vascular renal disease (C)		
19. DATE OF OPERATION 0			20. AUTOPSY? (Yes or No)		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work At Work			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from 3/5/65 to 4/1/65 that (I) (we) last saw the deceased alive on 3/5/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.			23A. SIGNATURE J. S. Shore J. S. M.D. Attending Phys. Med. Director Staff Phys.		
23B. DATE SIGNED 4-2-65			23C. PHYSICIAN'S NAME (Type) S. BOROFFSKY M.D.		
23D. ADDRESS 601 N. MONROE ST			24A. BURIAL CREMATION, REMOVAL (Specify) Burial		
24B. DATE 4/5/65			24C. NAME OF CEMETERY or CREMATORY Mt Auburn		
24D. LOCATION (City, town, or county) Baltimore			25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		
25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR ADDRESS 638 N. B. MONROE ST		

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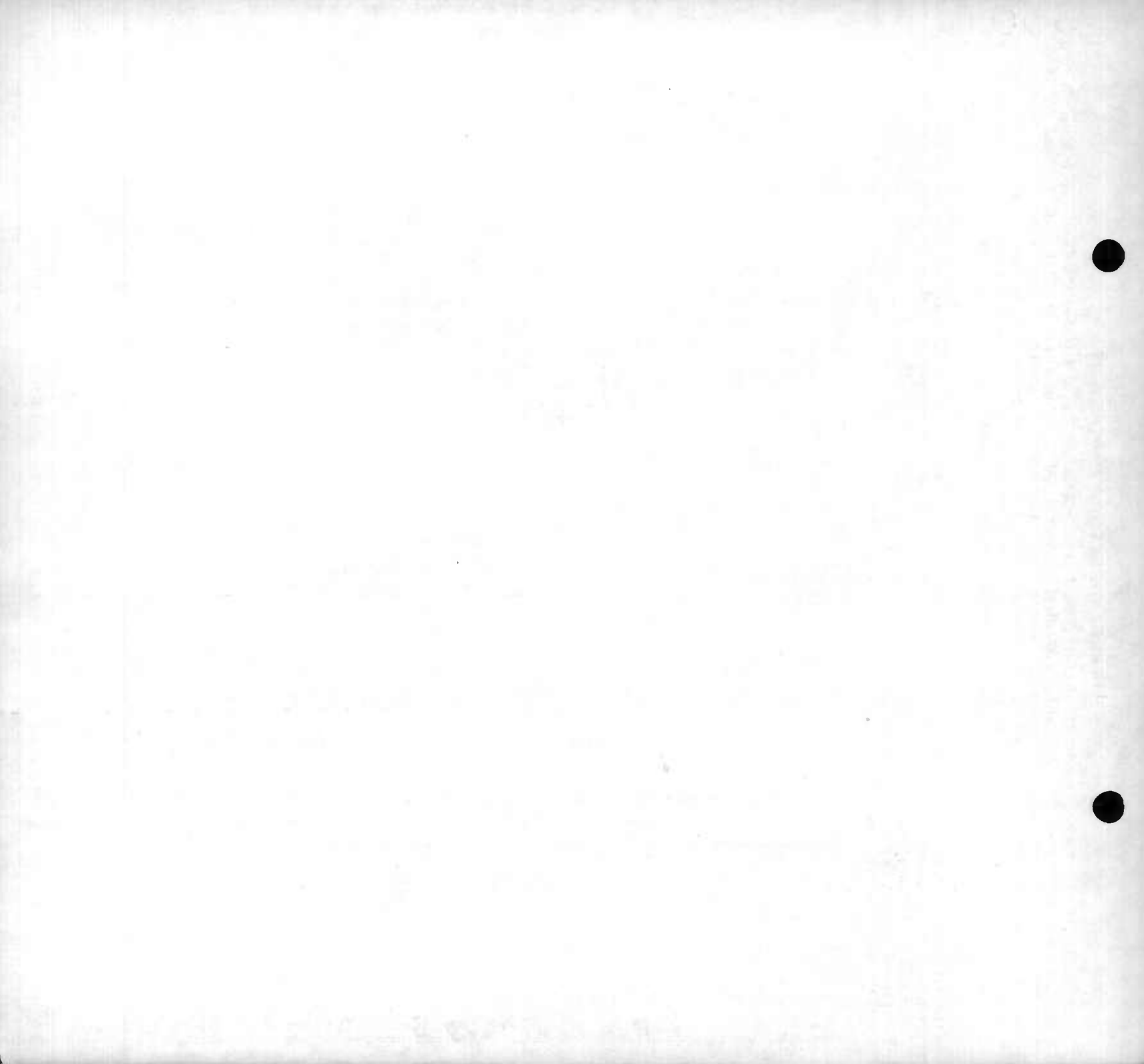
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3522		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3522	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) VINCENT INGRASSIA		2. DATE AND HOUR OF DEATH 4-1-65 2:48 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HDSPITAL DR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 9-08 C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO D. STREET ADDRESS (If rural, give location) 2134 AIKEN ST.			
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED (WIDOWED, DIVORCED (specify))	8. DATE OF BIRTH 2-19-84	9. AGE (In years last birthday) 81	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. LABORER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) ITALY	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME ALEXANDER INGRASSIA		14. MOTHER'S MAIDEN NAME ANTOINETTE GALELSTU			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-20-8810	17. INFORMANT ADDRESS Anna Schiano - 3322 Chesterfield Ave.		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) CARDIAC ARRHYTHMIA DUE TO (B) MYOCARDIAL INFARCTION DUE TO (C) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE		INTERVAL BETWEEN ONSET AND DEATH MIN 3 WKS 4 YRS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-17-65 to 4-1-65, that (I) (we) last saw the deceased alive on 4-1-65 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Daniel J. Foss		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-1-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4-5-65	24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cen.		24D. LOCATION (City, town, or county) (State) Balto, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965	25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR John C. Miller Inc.		ADDRESS -6415 Belair Rd.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3523				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3523	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>Bernard Franklin Gerver</b>				2. DATE AND HOUR OF DEATH <b>March 31, 1965 10:55 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hosp.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>706</b>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 18</b>			
				D. STREET ADDRESS (If rural, give location) <b>1912 E 29th Street</b>			
5. SEX <b>Male</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>4/9/1892</b>	9. AGE (In years last birthday) <b>72</b>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bus Driver</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael George Gerver</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Byrnes</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife - Irene Gerver</b>		ADDRESS <b>Same</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction - @ 6 hrs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>				CAUSE OF DEATH INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Severe Pulmonary Emphysema</b>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/31/65 8PM</b> to <b>3/31/65 10:55</b> , that (I) (we) last saw the deceased alive on <b>3/31</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Miriam C. Cohen</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>3-31-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>MIRIAM C. COHEN</b>				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-5-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore Natl. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>John E. Miller Inc. - 6415 Belair Rd.</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

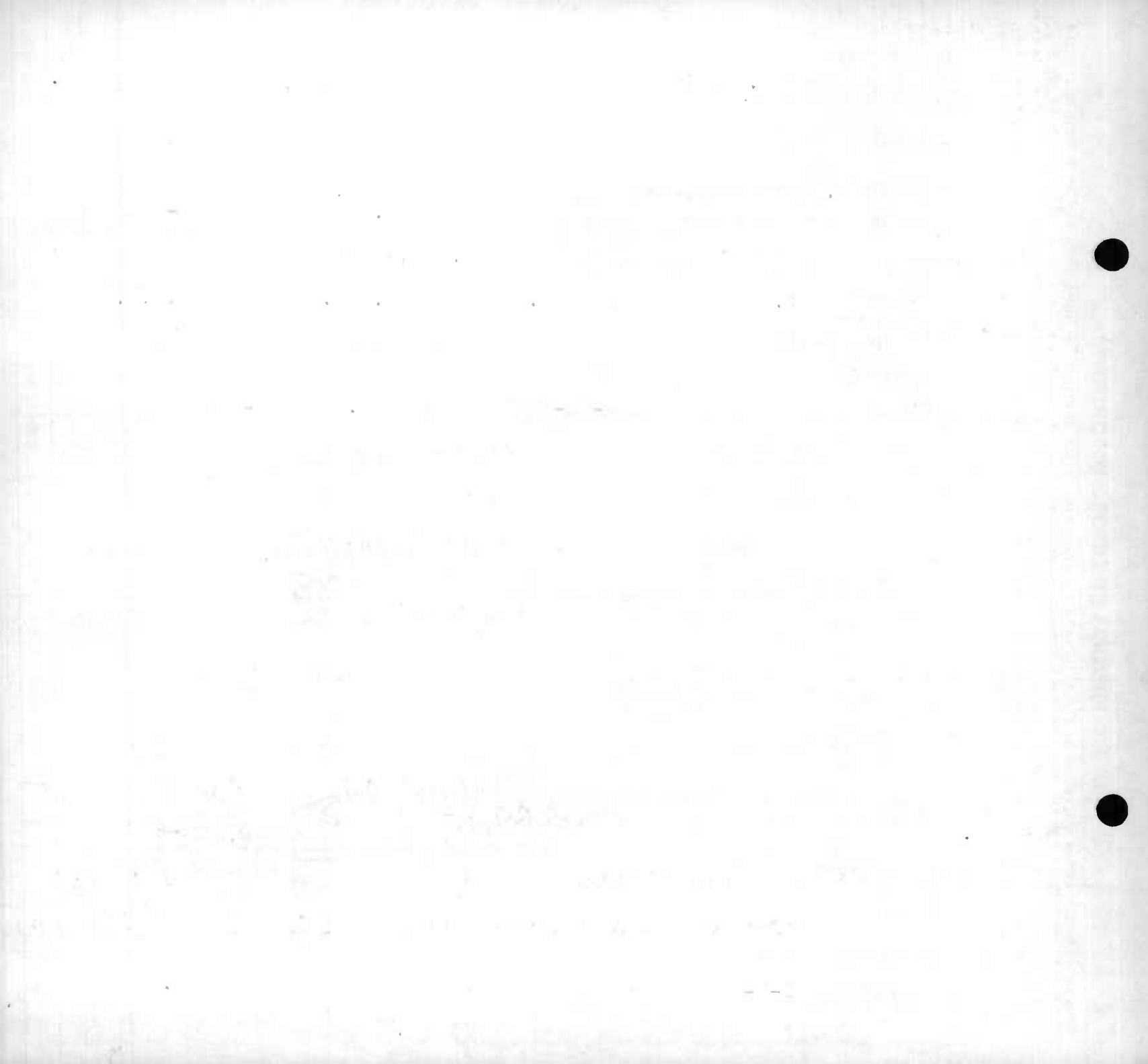
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 3524

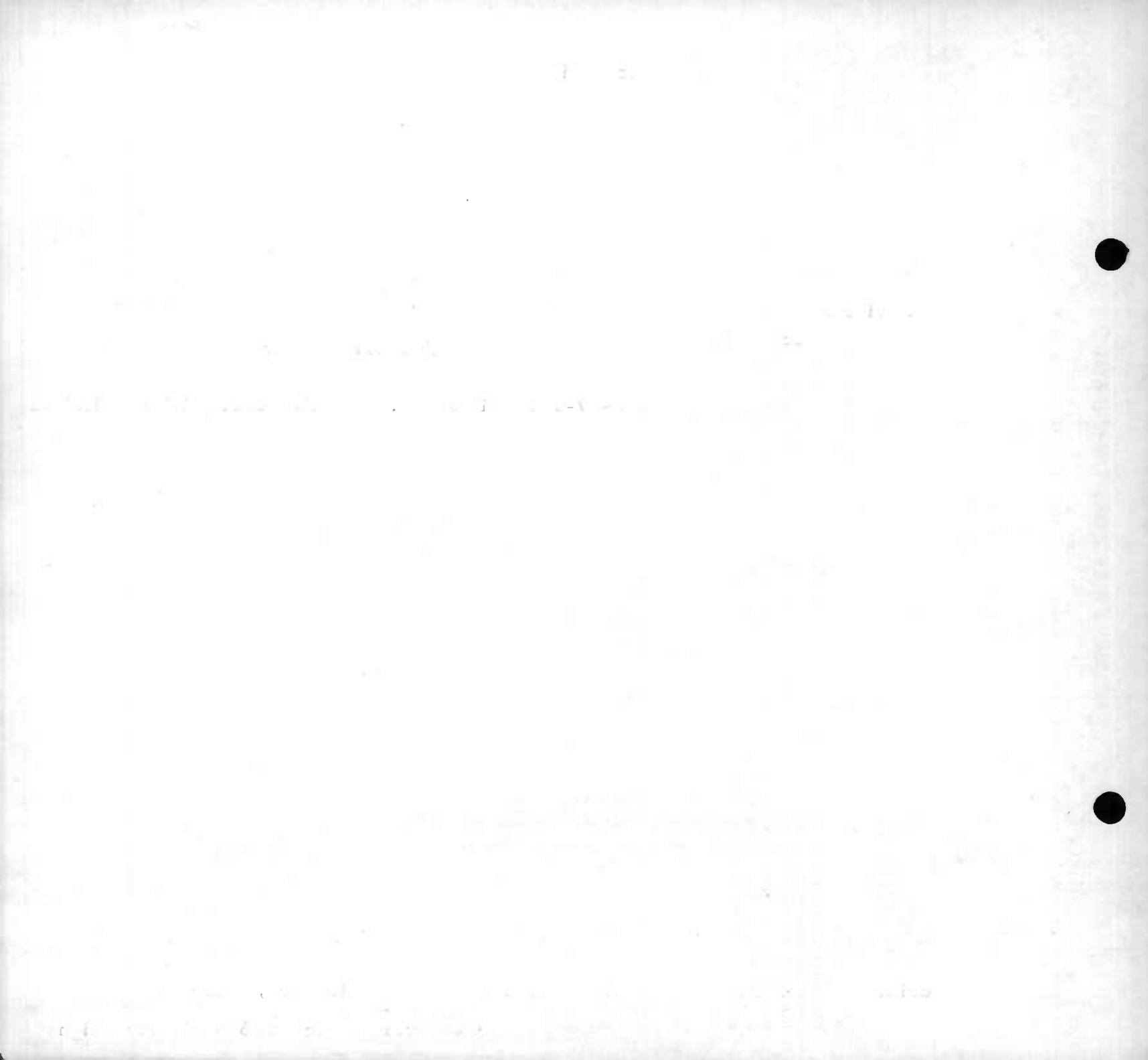
BIRTH NO. 65 3524		2. DATE AND HOUR OF DEATH April 1, 1965 3:05 A. M.	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) John R. Stolt		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21-02	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1207 W. O stend Street		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1207 W. Ostend Street -#30	
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH Oct. 14, 1898
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packing Dept.		10B. KIND OF BUSINESS OR INDUSTRY Butler Bros.	9. AGE (In years lost birthday) 66
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Max Stolt		14. MOTHER'S MAIDEN NAME Minnie Eversperger	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-01-5667	
17. INFORMANT Cynthia E. Stolt - Same		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.) 163XV-260X CAUSE OF DEATH CARCINOMA of the lung ACVD Diabetes mellitus Hypertension INTERVAL BETWEEN ONSET AND DEATH months " years Years.			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from July 14, 1961 to April 1, 1965, that (I) (we) last saw the deceased alive on March 29, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 4.1.65			
23A. SIGNATURE Henry Armanas		23B. DATE SIGNED 4.1.1965	
23C. PHYSICIAN'S NAME (Type) HENRY ARMANAS		23D. ADDRESS 1934 Wilkens Ave. Balto 23, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-3-65	
24C. NAME OF CEMETERY or CREMATORY Western Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR R. E. F. F. F.	
25C. FUNERAL DIRECTOR John C. Mollw Inc.		ADDRESS 6415 Belair Rd.	



# FUNERAL DIRECTOR: IMPORTANT

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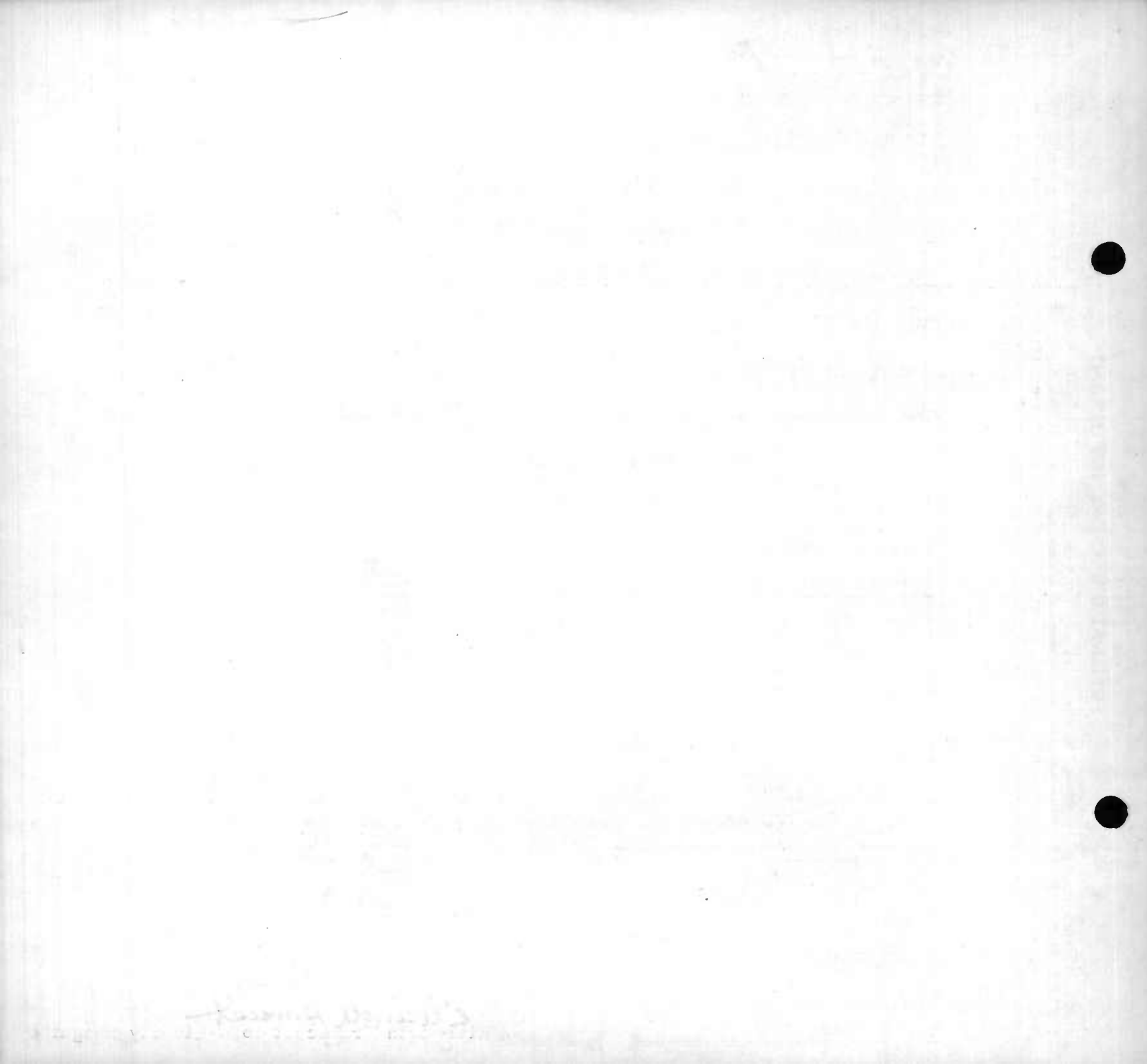
BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 65 3525					CERTIFICATE OF DEATH					Registered No. 65 3525					
1. NAME OF DECEASED (Type or Print) Edward P. Mackenzie					2. DATE AND HOUR OF DEATH March 30, 1965 12:55 P.M.										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)										
FULL NAME OF HOSPITAL OR INSTITUTION Maryland General Hospital					A. STATE Maryland					B. COUNTY 28-41					
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore										
					D. STREET ADDRESS (If rural, give location) 3604 Mohawk Ave										
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH March 4, 1887		9. AGE (In years last birthday) 78		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Baltimore Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Joseph Mackenzie					14. MOTHER'S MAIDEN NAME Elizabeth Pepler										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO. 215-07-8085					17. INFORMANT Mildred D. Baltz 3533 Milford Mill Road					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) Uremia DUE TO (B) Diabetes mellitus DUE TO (C)					INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION 0			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) No			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?									
22. I certify that (I) (this hospital) attended the deceased from March 30 1965 to March 30 1965, that (I) (we) last saw the deceased alive on March 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.															
23A. SIGNATURE L.S. Tilley					M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>					23B. DATE SIGNED March 30, 1965					
23C. PHYSICIAN'S NAME (Type) L.G. Tilley					23D. ADDRESS M.O. Maryland General Hospital										
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/2/65			24C. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland						
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965			25B. NAME OF REGISTRAR R. E. Taylor			25C. FUNERAL DIRECTOR Ellsworth Armacost			ADDRESS 4600 Liberty Heights						



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 3528</u>	
<div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. <u>65 3528</u></p> <p>M.E. CASE NO. <u>65 3528</u></p> <p>1. NAME OF DECEASED (Type or Print) <u>IRENE SHIFLET</u></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <u>April 1, 1965 9:45 A.M.</u></p> </div> </div>					
<p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>SINAI HOSPITAL</u></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</p> <p>A. STATE <u>Maryland</u> B. COUNTY <u>28-41</u></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u></p> <p>D. STREET ADDRESS (If rural, give location) <u>3606 Ferndale Ave</u></p>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>11-21-97</u>	9. AGE (In years, lost birthday) <u>67</u>	<p>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>HAGERSTOWN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Charles G. Hadley</u>			14. MOTHER'S MAIDEN NAME <u>Ida Mae Trezise</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>Charles Shiflet - 112 Welding Rd #26</u>			ADDRESS		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)			(A) <u>HASCUED w/ CHF</u>		
ANTECEDENT CAUSES			(B) DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			<u>① Diabetes Mellitus</u> <u>② Chronic Pyelonephritis</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>3-25</u> 19 <u>65</u> to <u>4-1</u> 19 <u>65</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>4-1</u> 19 <u>65</u> and that <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <u>(We)</u> <u>(did)</u> (did not) view the body after death.					
23A. SIGNATURE <u>Gregorio Martori</u>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4-1-65</u>
23C. PHYSICIAN'S NAME (Type) <u>GREGORIO MARTORI</u>			23D. ADDRESS <u>40 SINAI HOSPITAL</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/5/65</u>	24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT <u>APR 2 1965</u>		25B. NAME OF REGISTRAR <u>Robert J. Toland</u>		25C. FUNERAL DIRECTOR <u>Ellsworth Armacost</u> ADDRESS <u>4600 Liberty Heights</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT											
C-400 1 65 3527 CERTIFICATE OF DEATH					Registered No. 65 3527						
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)					2. DATE AND HOUR OF DEATH						
Mary Emma Cole					April 1, 1965						
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)						
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  5300 Belleville Avenue					A. STATE Maryland						
					B. COUNTY 28-02						
5. SEX Female					C. CITY OR TOWN (If outside city limits, write RURAL and give township)						
					Baltimore						
6. RACE White					D. STREET ADDRESS (If rural, give location)						
					5300 Belleville Avenue						
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed					8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.		
					March 8, 1878		87				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					11. BIRTHPLACE (State or foreign country)					12. CITIZEN OF WHAT COUNTRY?	
At Home					Baltimore, Md.					U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
Wesley Tarr					Dyer						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
No					None		Mary Herbert 5300 Belleville Avenue				
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) ARTERIOSCLEROTIC DUE TO					5 years	
					(B) HEART DISEASE DUE TO						
					(C)						
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					BRONCHOPNEUMONIA					2 Weeks	
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Fall 19 1963 April 1, 19 65, that (I) (we) last saw the deceased alive on April 1, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Marvin Goldstein					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED 4-1-65	
23C. PHYSICIAN'S NAME (Type) Marvin Goldstein					23D. ADDRESS 5334 Liberty Heights Avenue					BALTO. MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial					24B. DATE 4/5/65		24C. NAME of CEMETERY or CREMATORY New Cathedral Cemetery			24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965			25B. NAME OF REGISTRAR E. J. Fisher			25C. FUNERAL DIRECTOR Ellsworth Armacos			ADDRESS 4600 Liberty Heights		

Marvin Blalock





65 3528

BALTIMORE CITY HEALTH DEPARTMENT

65 3528

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GERALDINE HUNT

2. DATE AND HOUR PRONOUNCED DEAD

March 30, 1965

1:40 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY 99

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Glen Burnie 52-00

D. STREET ADDRESS (If rural, give location)

148 Steiny Road

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

South Baltimore General Hospital

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

March 14, 1932

9. AGE (In years  
last birthday)

33

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF  
WHAT COUNTRY?

U.S. 3528

13. FATHER'S NAME

Martin L. Hall

14. MOTHER'S MAIDEN NAME

Jessie Blanks

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Lee O. Hunt, 148 Stienly Ave., E. Glen Burnie, Md.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Isopropyl alcohol poisoning  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Acute and chronic ethylism  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Home

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

148 Steiny Road 52-00

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 30 65 ?

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Drank rubbing alcohol

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3-31-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-2-1965

23C. NAME of CEMETERY or CREMATORY

Glen Haven Memorial Pk.

23D. LOCATION

(City, town, or county)

(State)

Ritchie Hwy., A.A. Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 2 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

George J. Gonce

ADDRESS

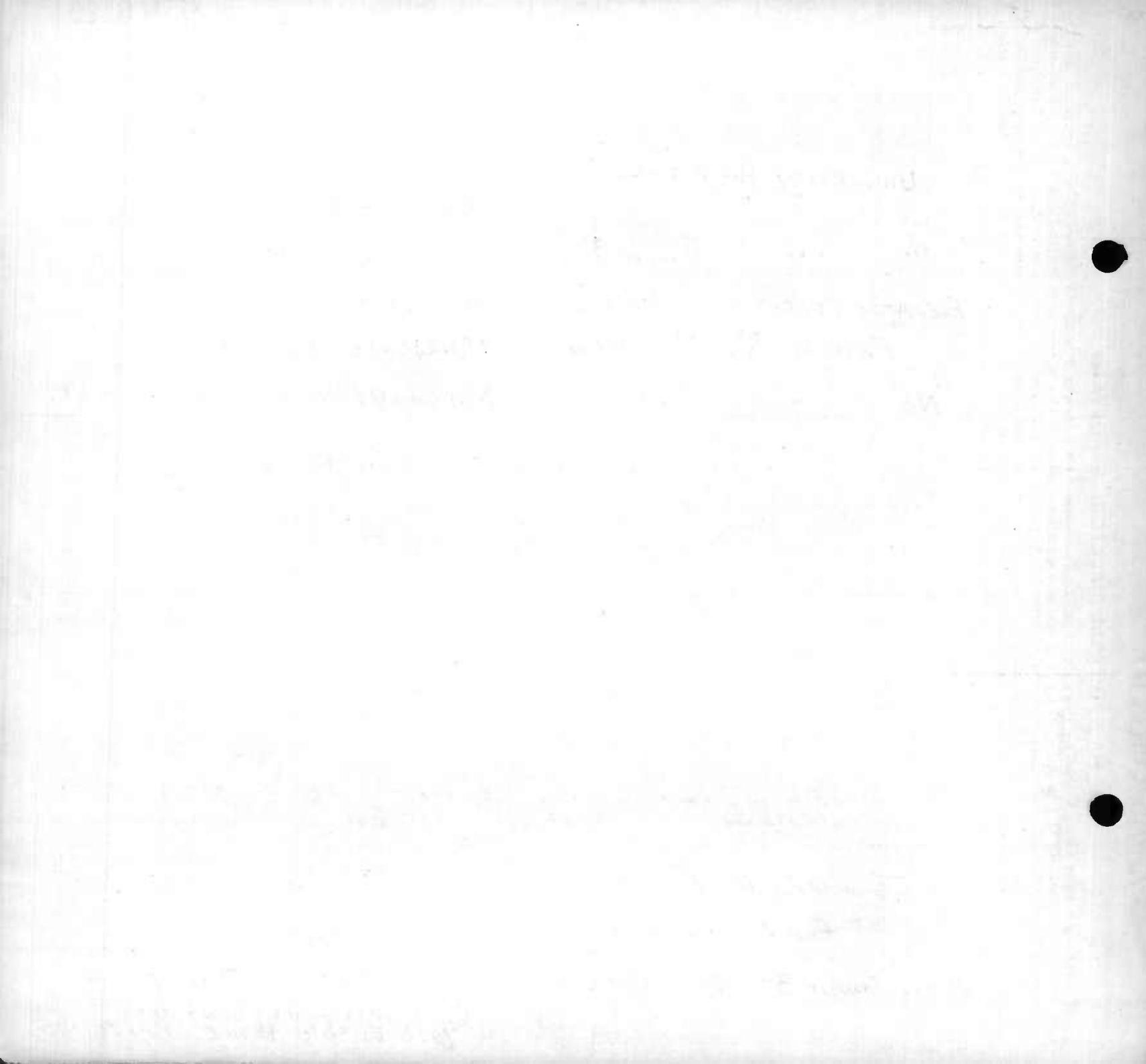
4001 Ritchie Hwy.

MAIL ROOM

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO.		65 3529		65 3529	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <i>Peckman, Walter</i>			2. DATE AND HOUR OF DEATH <i>3/27/65</i> <i>10:25 P. M.</i>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIVERSITY HOSPITAL</i>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>12-07</i> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i> D. STREET ADDRESS (If rural, give location) <i>112 West 25th St.</i>		
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Never Married</i>	8. DATE OF BIRTH <i>11/10/09</i>	9. AGE (In years last birthday) <i>54</i>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>ELEVATOR OPERATOR</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>HOTEL</i>		11. BIRTHPLACE (State or foreign country) <i>PENNSYLVANIA</i>	
13. FATHER'S NAME <i>FRANK R. PECKMAN</i>			14. MOTHER'S MAIDEN NAME <i>MARJORIE FINLEY</i>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>MARGERY DULCIE 1722 BOLTON ST.</i>	
18. <i>352X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <i>cardiovascular thrombosis</i> DUE TO (B) <i>essential hypertension</i> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/19/65</i> 19 <i>65</i> to <i>3/27</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>3/27</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Franklin M. Preiser</i>				23B. DATE SIGNED <i>3/27/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Franklin M. Preiser</i>				23D. ADDRESS <i>University Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL-TRANSIT</i>		24B. DATE <i>3-31-65</i>		24C. NAME of CEMETERY or CREMATORY <i>EVERGREEN</i>	
24D. LOCATION (City, town, or county) (State) <i>GETTYSBURG, PENNA.</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 2 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <i>JOHN O. MITCHELL &amp; SONS, INC., 6900 EUTAW PLACE BALTO. MD.</i>			



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 3530</b>		<b>CERTIFICATE OF DEATH</b>		65 3530	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Walter C. Wilhelm.</b>			March 30, 1965 3:10 p.m.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital.</b>			A. STATE <b>Maryland</b> B. COUNTY <b>13-08</b>		
5. SEX <b>Male</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
6. RACE <b>White</b>			D. STREET ADDRESS (If rural, give location) <b>4110 Falls Road.</b>		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>			8. DATE OF BIRTH <b>May 13, 1895</b>		
9. AGE (In years last birthday) <b>69</b>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Henry C. Wilhelm.</b>			14. MOTHER'S MAIDEN NAME <b>Emma Wink.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO.		
17. INFORMANT <b>Mrs. Anna Wilhelm.</b>			ADDRESS <b>4110 Falls Road.</b>		
18. <b>420.0 I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			(A) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>2 years</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C)		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 19 60</b> to <b>30 MARCH 19 65</b> , that (I) (we) last saw the deceased alive on <b>26 MAR 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>John B. DeHoff</i>				23B. DATE SIGNED <b>31 Mar 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>John B. DeHoff</b>				23D. ADDRESS <b>1701 Meridene Drive</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/2/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Pine Grove</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Co, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Jackson</b>		25C. FUNERAL DIRECTOR <b>August E. Donovan</b>			
25D. ADDRESS <b>3818 Roland Ave</b>					

Miss Alice Jones

1000 13th St. N.W.

Washington

D.C. 20004

Dear Miss Jones:

Enclosed please find

Yours truly,  
J. Edgar Hoover

*[Handwritten signature]*

cc

2

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3531	
BIRTH NO. 65 3531		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Conley, Thomas Calvin</u>		2. DATE AND HOUR OF DEATH <u>3/31/65</u> <u>11:25a</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Md</u> B. COUNTY <u>13-07</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>The Union Memorial Hospital</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If total, give location) <u>3647 Chestnut Ave.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>3/16/03</u>	9. AGE (In years last birthday) <u>62</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>LEO J. McCOURT</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Harry Conley</u>		14. MOTHER'S MAIDEN NAME <u>Annie Bell Ward</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 2nd W.W.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>HAZEL M. CONLEY-3647 CHESTNUT AVE</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Cardiac Arrest</u> DUE TO (B) <u>Ventricular Fibrillation</u> DUE TO (C) <u>Myocardial Infarction &amp; Congestive Failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u>	
MEDICAL CERTIFICATION		19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <u>3/15/1965</u> to <u>3/31/1965</u> , that (we) last saw the deceased alive on <u>3/31/1965</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>William B. Long</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/31/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>WILLIAM B. LONG</u>		23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL 33 RD &amp; CALVERT STS. # 18</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/365</u>	24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park</u>		24D. LOCATION (City, town, or county) (State) <u>Windsor Mill Rd, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 2 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor M.D.</u>	

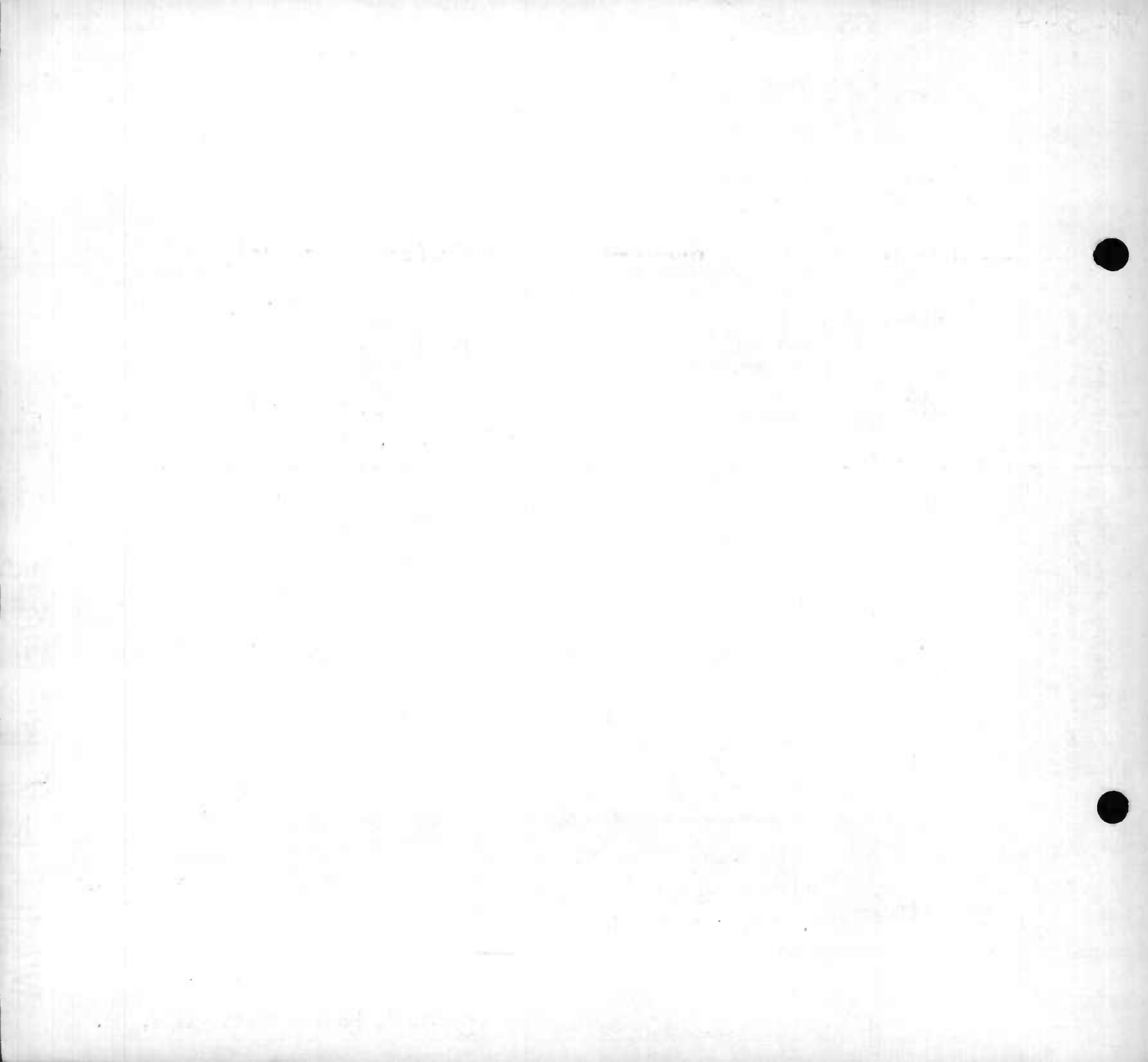
80



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

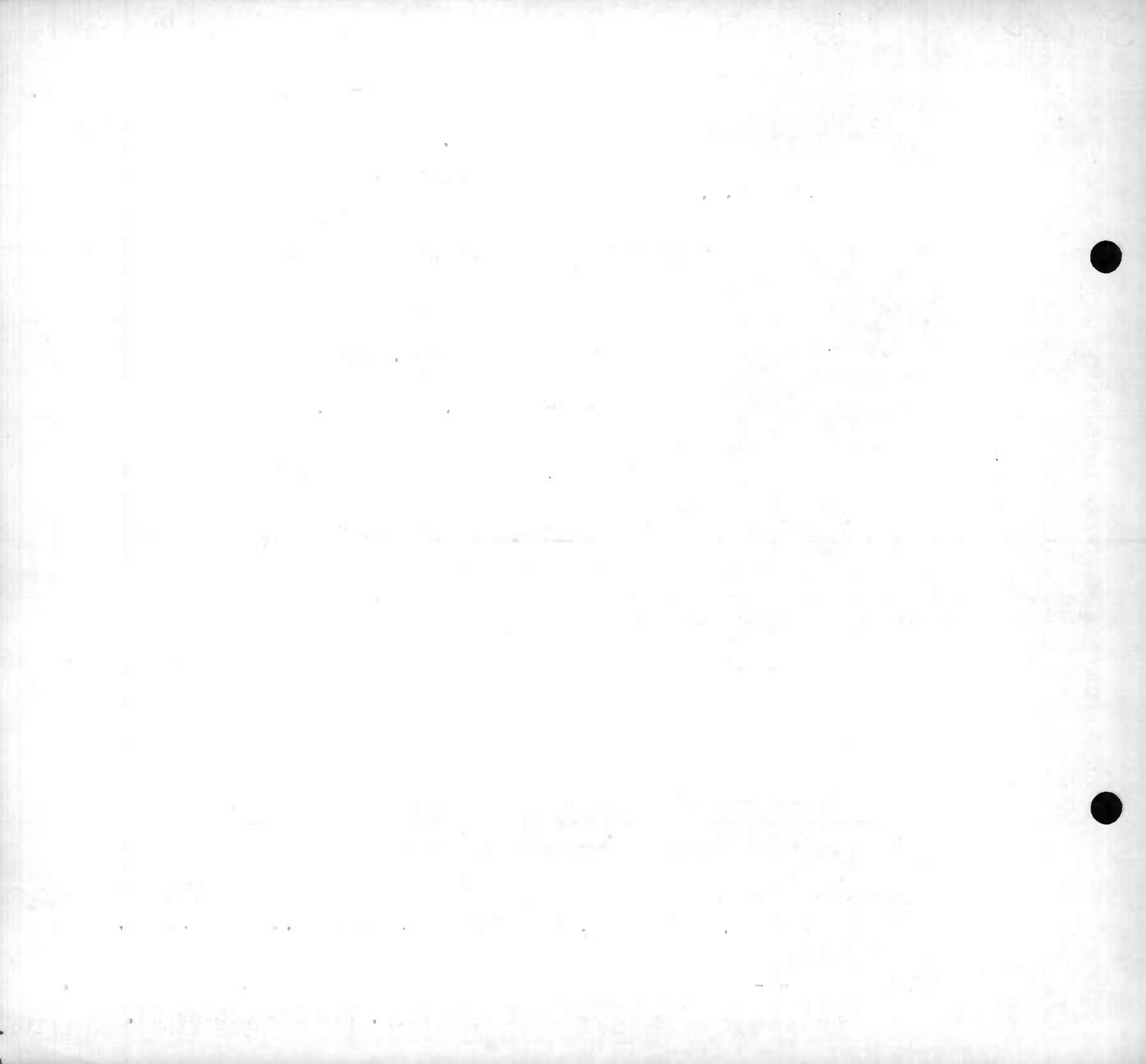
BIRTH NO. <b>65 3532</b>		Baltimore City Health Department <b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 3532</b>	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>Connie S Wann</b>			2. DATE AND HOUR OF DEATH <b>3/28/65 6:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF INSTITUTE (If not in hospital or institution, give street address or location) <b>University Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Pr. Prince</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Hillside 66-00</b> D. STREET ADDRESS (If rural, give location) <b>1505 59th Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>divorced</b>	8. DATE OF BIRTH <b>9/21/25</b>	9. AGE (In years last birthday) <b>39 41</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Meat wrapper</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Safeway Stores</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
13. FATHER'S NAME <b>Clifford Clyburn</b>			14. MOTHER'S MAIDEN NAME <b>Ruby Hicks</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-28-9768</b>		17. INFORMANT ADDRESS <b>Patricia Felker Hillside, Ind.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>199.2.1</b> <b>A. G. F. Hemorrhage</b> <b>B. Carcinoma of Lung and Pancreas</b> DUE TO (B) <b>Pancreas</b> DUE TO (C) _____			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>1/3/24/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma Pancreas</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/26</b> 19 <b>65</b> to <b>3/28</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3/28</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="radio"/> (did not) view the body after death.					
23A. SIGNATURE <b>Jonathan Tuerk</b>				23B. DATE SIGNED <b>3/28/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Jonathan Tuerk</b>		23D. ADDRESS <b>M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>3/23/65</b>	24C. NAME OF CEMETERY <b>George Washington</b>		24D. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>R. E. Stachurski</b>		25C. FUNERAL DIRECTOR ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 3533</b>		<b>CERTIFICATE OF DEATH</b>		65 3533	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Eleanor Chaney Grubb</b>		2. DATE AND HOUR OF DEATH <b>3-30-65 3:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>12-01</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Edgewood N.H.</b>		D. STREET ADDRESS (If rural, give location) <b>3607 Greenway</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>6-15-1882</b>	9. AGE (In years last birthday) <b>82</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Medical</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Taylor Grubb</b>		14. MOTHER'S MAIDEN NAME <b>Emma J. Lyon</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-22-0767</b>		17. INFORMANT <b>Dr. Wilson L. Grubb</b>	
18. <b>491X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Brondipneumonia</b> <b>Atherosclerotic heart</b> <b>Diabetes</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1955</b> to <b>Mar 30 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>24 Mar 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) did not view the body after death.					
23A. SIGNATURE <b>Louis P. Hamburger, Jr.</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>Mar 31 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Louis P. Hamburger, Jr.</b>		23D. ADDRESS <b>1001 St. Paul St., Balto., Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-1-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore,</b>		24E. LOCATION (State) <b>Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Calab E. Jenkins</b>		25C. FUNERAL DIRECTOR <b>Henry W. Jenkins &amp; Sons Co.</b>	
				ADDRESS <b>4905 York Road Balto.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3534		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3534	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LEWIS GRAHAM DOYLE</b>		2. DATE AND HOUR OF DEATH <b>3/28/65</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>MO GEN. HOSP.</b>		A. STATE <b>MO.</b>		B. COUNTY <b>27-44</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN <b>BALTO.</b>		(If outside city limits, write RURAL and give township)	
		D. STREET ADDRESS (If rural, give location) <b>4131 MARY AVE</b>			
5. SEX <b>M.</b>	6. RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2/10/03</b>	9. AGE in years last birthday <b>62</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ELECTRICIAN</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TRAFFIC Com.</b>		11. BIRTHPLACE (State or foreign country) <b>ST. LOUIS MO.</b>	
13. FATHER'S NAME <b>LEWIS Summerfield</b>		14. MOTHER'S MAIDEN NAME <b>MARY H. PAYNE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-40-2480</b>		17. INFORMANT <b>WIFE</b>	
18. <b>420.1 I</b>		D. CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CERTIFICATION APPROVED BY:  M.D. CHIEF OF ASST. MEDICAL EXAMINER <b>3/30/65</b>		Acute Myocardial infarction Coronary occlusion	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-18-1964</b> to <b>2-15-1965</b> , that (I) (we) last saw the deceased alive on <b>2-15-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>G. R. Sadjadi</b>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>3-30-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>G. R. SADJADI</b>		23D. ADDRESS <b>5829 BELAIR RD. BALTO. MD 21206</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/1/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER</b>	
				24D. LOCATION (City, town, or county) (State) <b>BALTO MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>		25C. FUNERAL DIRECTOR <b>PA. HEERMANN - 6067 HARFORD</b>	
				ADDRESS	

Lewis Gunners Field

5114 40-5480

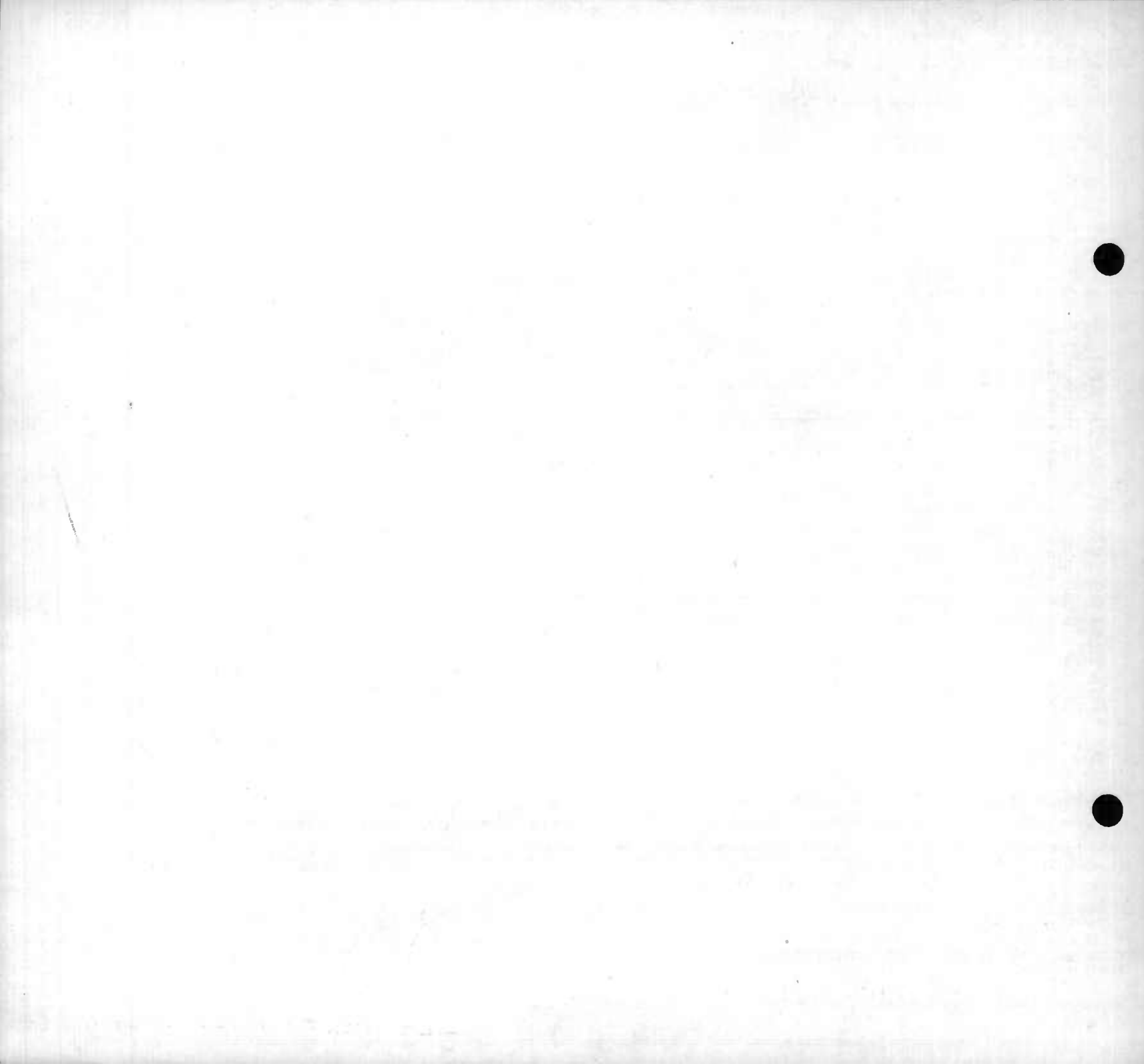
Acute Myocardial  
Infarction  
Covering section

- Jacobson F. J. 1951-  
1952

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3535				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3535	
M.E. CASE NO. 65 3535				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>NELLIE NELSON</b>				2. DATE AND HOUR OF DEATH <b>3-28-65 11.30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE <b>MARYLAND</b>		B. COUNTY <b>15-47</b>	
<b>3106 WINDSOR AVE</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>3106 WINDSOR AVE</b>			
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED</b> DIVORCED (specify)		8. DATE OF BIRTH <b>2-18-1886</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CARTER NELSON</b>				14. MOTHER'S MAIDEN NAME <b>MARCELLA</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HILDA THOMAS</b>		ADDRESS <b>3106 WINDSOR AVE</b>	
18. <b>422.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Arteriosclerotic Cardiovascular disease</b> DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO			
				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
<b>0</b>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>JUNE 30 1964</b> to <b>MARCH 28 1965</b> , that (I) (we) last saw the deceased alive on <b>MARCH 24 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>William H. Watts</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>William H. Watts</b>				23D. ADDRESS <b>515 N. ALBANY AVE BALTIMORE MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>BURIAL</b>		<b>4-2-65</b>		<b>MOUNT AUBURN</b>		<b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<b>APR 2 1965</b>		<b>Robert E. Jenkins</b>		<b>IGLEBROWN &amp; SON</b>		<b>123 W. MONTGOMERY ST.</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65 3536</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 3536</u>	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		SCHMINKE, MARGARET M.		2. DATE AND HOUR OF DEATH 4-1-65 2:10A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		1608	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
ST. AGNES HOSPITAL		BALTIMORE		ZONE 21229	
D. STREET ADDRESS (If rural, give location)		605 MT. HOLLY STREET			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-18-06	9. AGE (In years last birthday) 58	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
HOUSEWIFE				MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		CLETUS KINSEY		MABLE HOWE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				ST. AGNES RECORDS - CATON & WILKENS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
150X I		Metastatic Carcinoma of Esophagus		6-12 mo.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO			
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 13 1965 to APRIL 1 1965, that (I) (we) last saw the deceased alive on APRIL 1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Stell. Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		April 1, 1965	
		M.D. ST. AGNES HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/3/65		Landon Pl. Bosto. Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 2 1965		Robert E. Taylor, M.D.		W. H. H. 4101 Edmondson	
				ADDRESS	

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3537		BALTIMORE CITY HEALTH DEPARTMENT	
M.E. CASE NO.		CERTIFICATE OF DEATH X Registered No. 65 3537	
1. NAME OF DECEASED (Type or Print) ODA GAITLEY		2. DATE AND HOUR OF DEATH April 2, 1965 3:45 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE CORRECTED 4-8-65</b> (If not in hospital or institution, give street address or location) St. Joseph Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY Baltimore 34 Balto 53-00	
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-28-1894 1-28-99
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 71
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harry G. Coulter		14. MOTHER'S MAIDEN NAME Sarah Sara Norris	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Marian K. Murphy
18. 260X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) Diabetic Coma		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.		(B) Cerebral Vascular Accident	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)	
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 3/21 19 65 to 4/2 1965 that (I) (we) lost saw the deceased alive on 4/2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE S. Viriyapongse		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	23B. DATE SIGNED 4/2/65
23C. PHYSICIAN'S NAME (Type) Sukhe Viriyapongse		23D. ADDRESS 1400 N. Caroline Street	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/6/65	24C. NAME of CEMETERY or CREMATORY Gardens of Faith	24D. LOCATION (City, town, or county) (State) Balto., Md.
25A. DATE REC'D BY HEALTH DEPT. APR 2 1965		25B. NAME OF REGISTRAR Robert E. Stokely	25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc., Balto., Md.

V.S. 153

4-8-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 3538

BIRTH NO.

65 3538

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Rose Veneziano

2. DATE AND HOUR OF DEATH

4-1-65

3:45 P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Md.

Balto.

2738

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

5754 Maple Hill Rd.

# 14

5. SEX

f

6. RACE

w

7. MARRIED, NEVER MARRIED

WIDOWED, DIVORCED (specify)

w

8. DATE OF BIRTH

12-5-86

9. AGE (In years last birthday)

78

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

ITALY

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

name

FIRST

UNKNOWN MATILDA

14. MOTHER'S MAIDEN NAME

Grace Matilda

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Acc Rm chart

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) pneumonia & ? CVA

7 days

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) malnutrition, dehydration

months

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

urinary tract infection

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

While At Work ☐

Not While At Work ☐

22. I certify that (I) (this hospital) attended the deceased from 3-23 1965 to 4-1-1965, that (I) (we) last saw the deceased alive on 4-1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4-1-65

23C. PHYSICIAN'S NAME (Typed)

Joseph Marr

23D. ADDRESS

M.D.

Johns Hopkins Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

4/5/65

24C. NAME OF CEMETERY or CREMATORY

HOLY REDEEMER CEMETERY

24D. LOCATION (City, town, or county) (State)

BALTIMORE, MD.

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

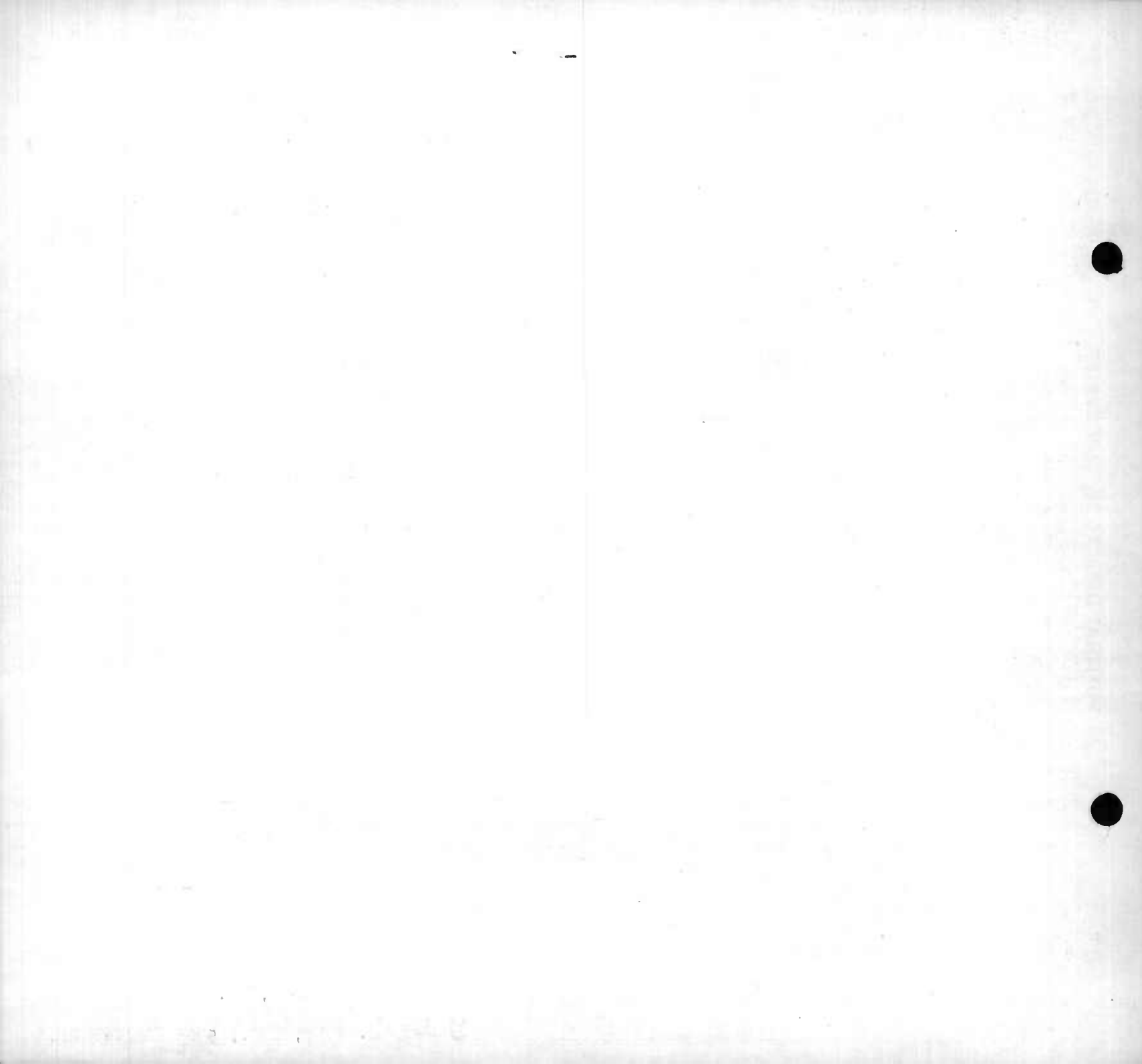
25C. FUNERAL DIRECTOR

ADDRESS

APR 2 1965

Robert E. Staley

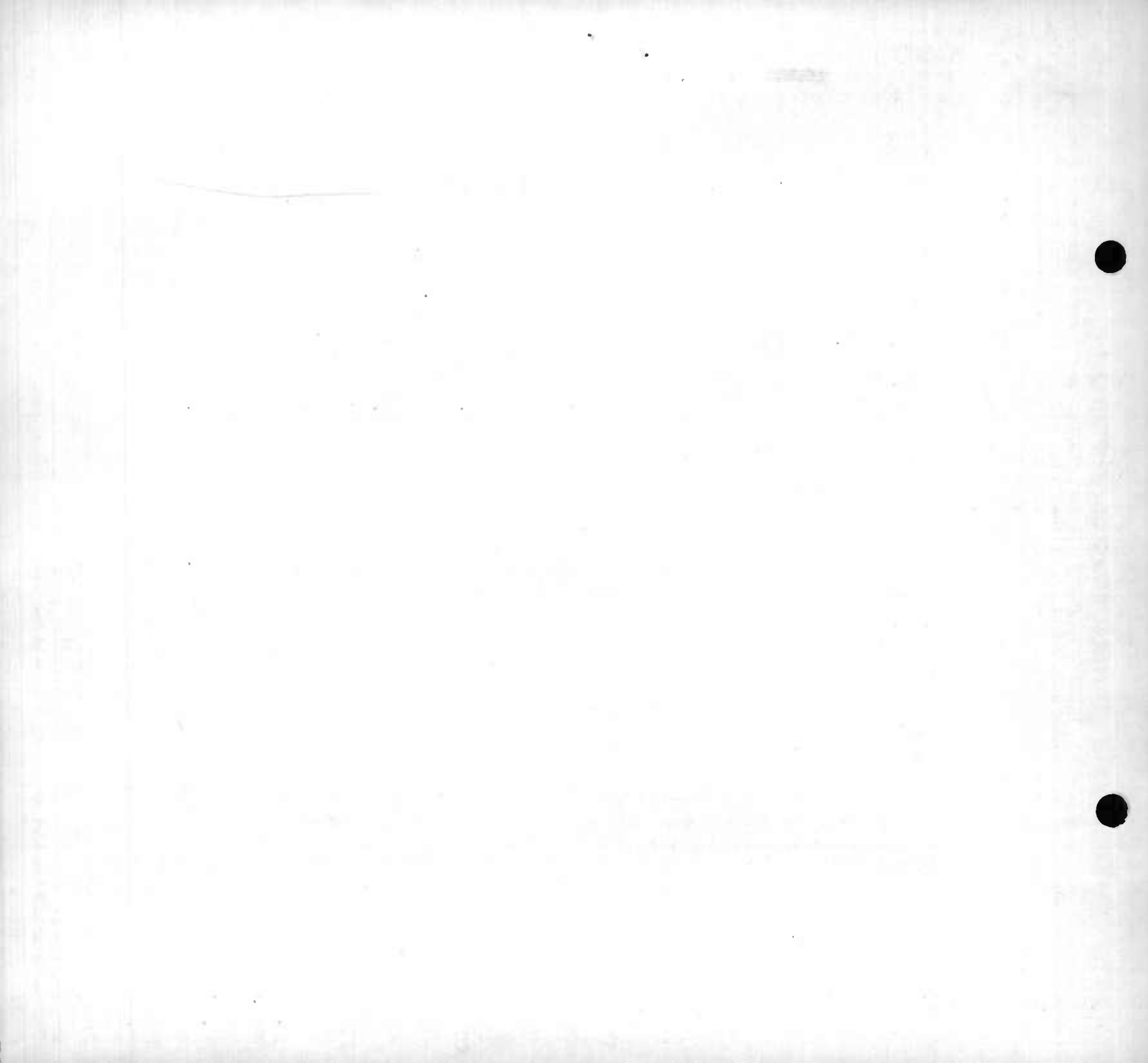
LEONARD J. RUCK, INC., 5305 HARFORD RD.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3539				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3539	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) <b>Edna V. HEALY</b>		2. DATE AND HOUR OF DEATH <b>April 1, 1965 2:35 AM</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Sinai Hospital of Baltimore</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>2214 Corbin Rd #14</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>8/21/87</b>	9. AGE (In years lost birthday) <b>77</b>	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Charles J. Trueman</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Wood</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>217051634</b>		17. INFORMANT <b>Mrs. Edna R. Warnick</b>		
18. <b>153,31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Intestinal Obstruction - Anemia</b>			CAUSE OF DEATH (A) <b>Carcinoma of Sigmoid with wide spread to left urether, left ovary, bladder, uterus</b> DUE TO (C) <b>pyelonephrosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>five months</b>		
19A. DATE OF OPERATION <b>1-3-31-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>intestinal obstruction</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3-MARCH 1965</b> to <b>April 1 1965</b> , that (I) (we) last saw the deceased alive on <b>April 1 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jorge Ordóñez</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 1, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Jorge Ordóñez</b>				23D. ADDRESS <b>2844 OAKLEY AVE. BAL. 15</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 2 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Leonard Ruck Inc. Balto. Md</b>		ADDRESS <b>21214</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 3540					CERTIFICATE OF DEATH			Registered No. 65 3540	
1. NAME OF DECEASED (Type or Print) DAVIS MRS LILLIAN M.					2. DATE AND HOUR OF DEATH 3-29-1965 2-25P M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
Church Home and Hospital		Baltimore 31, Md			Maryland		603		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					Baltimore 31				
D. STREET ADDRESS (If rural, give location)					2209 E. Fayette St				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Female	White	Married		3-26-08	57 yrs	Housewife		Maryland	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME		
Housewife		-		U.S.A.			George Wittig		
14. MOTHER'S MAIDEN NAME					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
Lillie Groves					No				
16. SOCIAL SECURITY NO.					17. INFORMANT				
-					Mr. Richard T. Davis Jr. 2209 E. Fayette St.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					19. CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					Acute Myocardial Infarction				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO				
					Uremia				
					(C) DUE TO				
					Congenital Polycystic Kidney - life long				
II					INTERVAL BETWEEN ONSET AND DEATH				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					10 days				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
2				Yes		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
-		-		-		-			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
-		While At Work <input type="checkbox"/> - At Work <input type="checkbox"/>		-					
22. I certify that (I) (this hospital) attended the deceased from 3-7-1965 19 to 3-29-65 19 that (I) (we) last saw the deceased alive on 3-29 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					23B. DATE SIGNED			23C. PHYSICIAN'S NAME (Type)	
Kishor C. Mehta					3-29-65			KISHOR C. MEHTA	
23D. ADDRESS					24. BURIAL CREMATION, REMOVAL (Specify)				
M.D. Church Home and Hospital, Balt. 31, Md.					BURIAL				
24B. DATE					24C. NAME of CEMETERY or CREMATORY				
4-2-65					OAK LAWN CEM.				
24D. LOCATION (City, town, or county) (State)					25A. DATE REC'D BY HEALTH DEPT.				
BALTO., Md.					APR 2 1965				
25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR				
Robert E. Stokely					Charles Miller - 2334 Jefferson St.				

Handwritten text at the top of the page, mostly illegible.

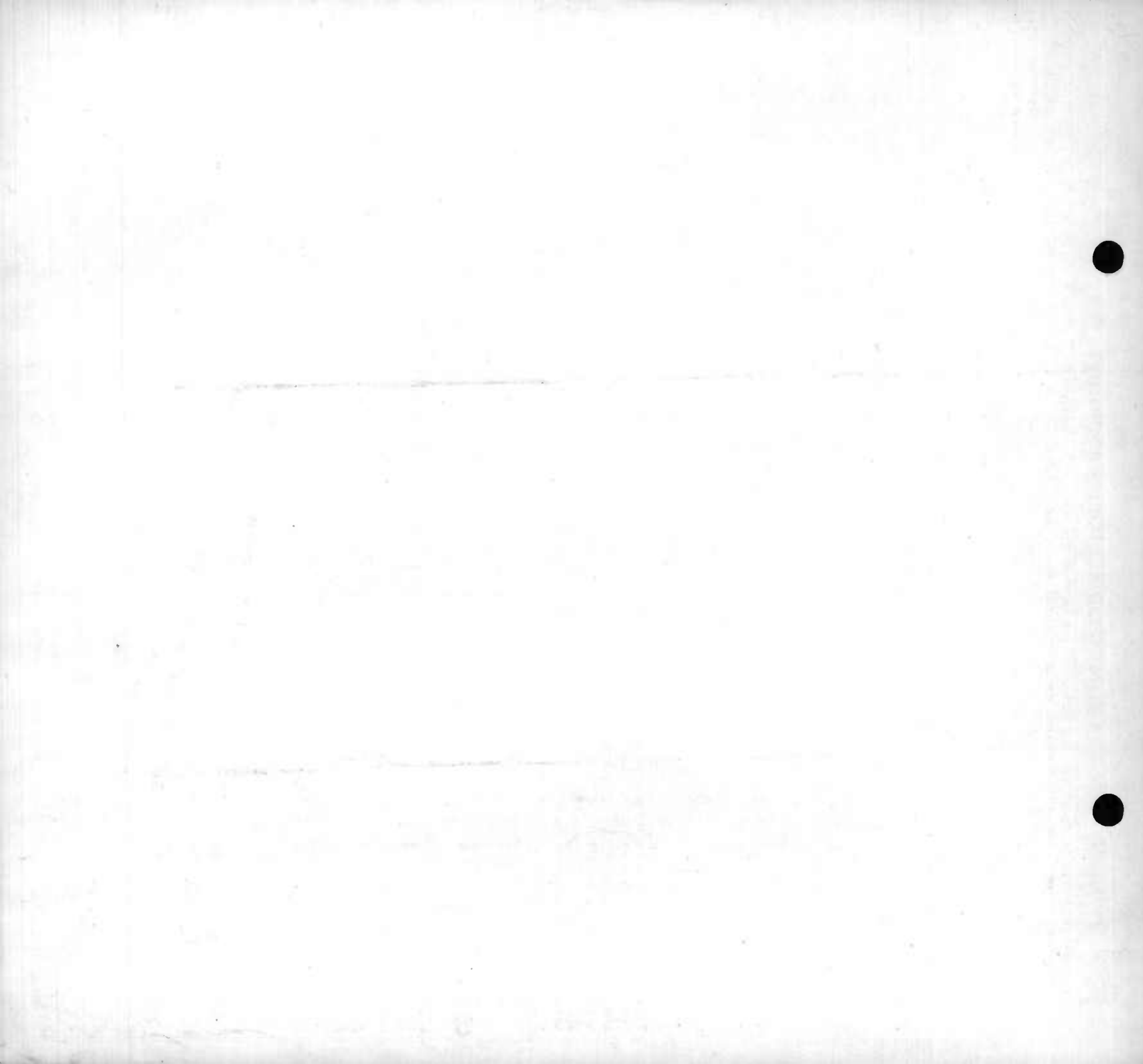
Main body of handwritten text, appearing to be a list or series of notes. Includes phrases like "The first", "The second", "The third", "The fourth", "The fifth", "The sixth", "The seventh", "The eighth", "The ninth", "The tenth", "The eleventh", "The twelfth", "The thirteenth", "The fourteenth", "The fifteenth", "The sixteenth", "The seventeenth", "The eighteenth", "The nineteenth", "The twentieth", "The twenty-first", "The twenty-second", "The twenty-third", "The twenty-fourth", "The twenty-fifth", "The twenty-sixth", "The twenty-seventh", "The twenty-eighth", "The twenty-ninth", "The thirtieth", "The thirty-first", "The thirty-second", "The thirty-third", "The thirty-fourth", "The thirty-fifth", "The thirty-sixth", "The thirty-seventh", "The thirty-eighth", "The thirty-ninth", "The fortieth", "The forty-first", "The forty-second", "The forty-third", "The forty-fourth", "The forty-fifth", "The forty-sixth", "The forty-seventh", "The forty-eighth", "The forty-ninth", "The fiftieth", "The fifty-first", "The fifty-second", "The fifty-third", "The fifty-fourth", "The fifty-fifth", "The fifty-sixth", "The fifty-seventh", "The fifty-eighth", "The fifty-ninth", "The sixtieth", "The sixty-first", "The sixty-second", "The sixty-third", "The sixty-fourth", "The sixty-fifth", "The sixty-sixth", "The sixty-seventh", "The sixty-eighth", "The sixty-ninth", "The seventieth", "The seventy-first", "The seventy-second", "The seventy-third", "The seventy-fourth", "The seventy-fifth", "The seventy-sixth", "The seventy-seventh", "The seventy-eighth", "The seventy-ninth", "The eightieth", "The eighty-first", "The eighty-second", "The eighty-third", "The eighty-fourth", "The eighty-fifth", "The eighty-sixth", "The eighty-seventh", "The eighty-eighth", "The eighty-ninth", "The ninetieth", "The ninety-first", "The ninety-second", "The ninety-third", "The ninety-fourth", "The ninety-fifth", "The ninety-sixth", "The ninety-seventh", "The ninety-eighth", "The ninety-ninth", "The hundredth".

Handwritten text at the bottom of the page, including a signature and date.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3541		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3541	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ALIP EL		2. DATE AND HOUR OF DEATH 4-1-65 8:25 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1603			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN HOSPITAL OF MARYLAND		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1705 W. LAFAYETTE AVE			
5. SEX M	6. RACE C	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SEPARATED	8. DATE OF BIRTH 6-28-33	9. AGE (In years last birthday) 31	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Nathaniel EL		14. MOTHER'S MAIDEN NAME Pearl Manuel		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Geraldine EL 1829 Edmondson Ave.	
18. 5-810 I		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) HEPATIC COMA DUE TO AND			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) BLEEDING ESOPHAGIAL VARICES DUE TO			
		(C) PORTAL CIRRHOSIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-31 1965 to 4-1 1965, that (I) (we) last saw the deceased alive on 4-1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Jesus G. Santiano		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-1-65	
23C. PHYSICIAN'S NAME (Type) Jesus G. Santiano		23D. ADDRESS M.D. LUTHERAN HOSPITAL OF Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/5/65	24C. NAME OF CEMETERY or CREMATORY Bolto. National Cem.		24D. LOCATION (City, town, or county) (State) Bolto. Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR Robert E. Stodum		25C. FUNERAL DIRECTOR ADDRESS B. Belated 918 Druid Hill Ave.	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 3542

BIRTH NO. 65 3542

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Fred Wilson

2. DATE AND HOUR OF DEATH

March 30, 1965

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Steversons Guest House  
2405 Roslyn Ave

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore 17,

D. STREET ADDRESS (If rural, give location)

#632 N Fulton Ave

5. SEX

M

6. RACE

C

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

7/1899

9. AGE (In years last birthday)

66

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Porter

10B. KIND OF BUSINESS OR INDUSTRY

Store

11. BIRTHPLACE (State or foreign country)

North Carolina

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.  
213-18-0217

17. INFORMANT

Mrs Mildred Williams 632 N Fulton Ave

ADDRESS

18. 442X1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO

(B) DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

3 hrs.

1 yr.

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from Mar 1953 to Mar 30 1965, that (I) lost saw the deceased alive on 15 Jan 1965 and that in (my) own opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James H. Carter

M.D.

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

2 April 1965

23C. PHYSICIAN'S NAME (Type)

James H. Carter

23D. ADDRESS

M.D.

1277 Pennsylvania St.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

4/3/65

24C. NAME of CEMETERY or CREMATORY

St. Calvary

24D. LOCATION

Adams County and

25A. DATE REC'D BY HEALTH DEPT.

APR 5 1965

25B. NAME OF REGISTRAR

Robert E. Sullivan

25C. FUNERAL DIRECTOR

Adolphus Halstead

ADDRESS

918 Druid Hill Ave

2. 1. 1900

2. 1. 1900

2. 1. 1900

2. 1. 1900

2. 1. 1900

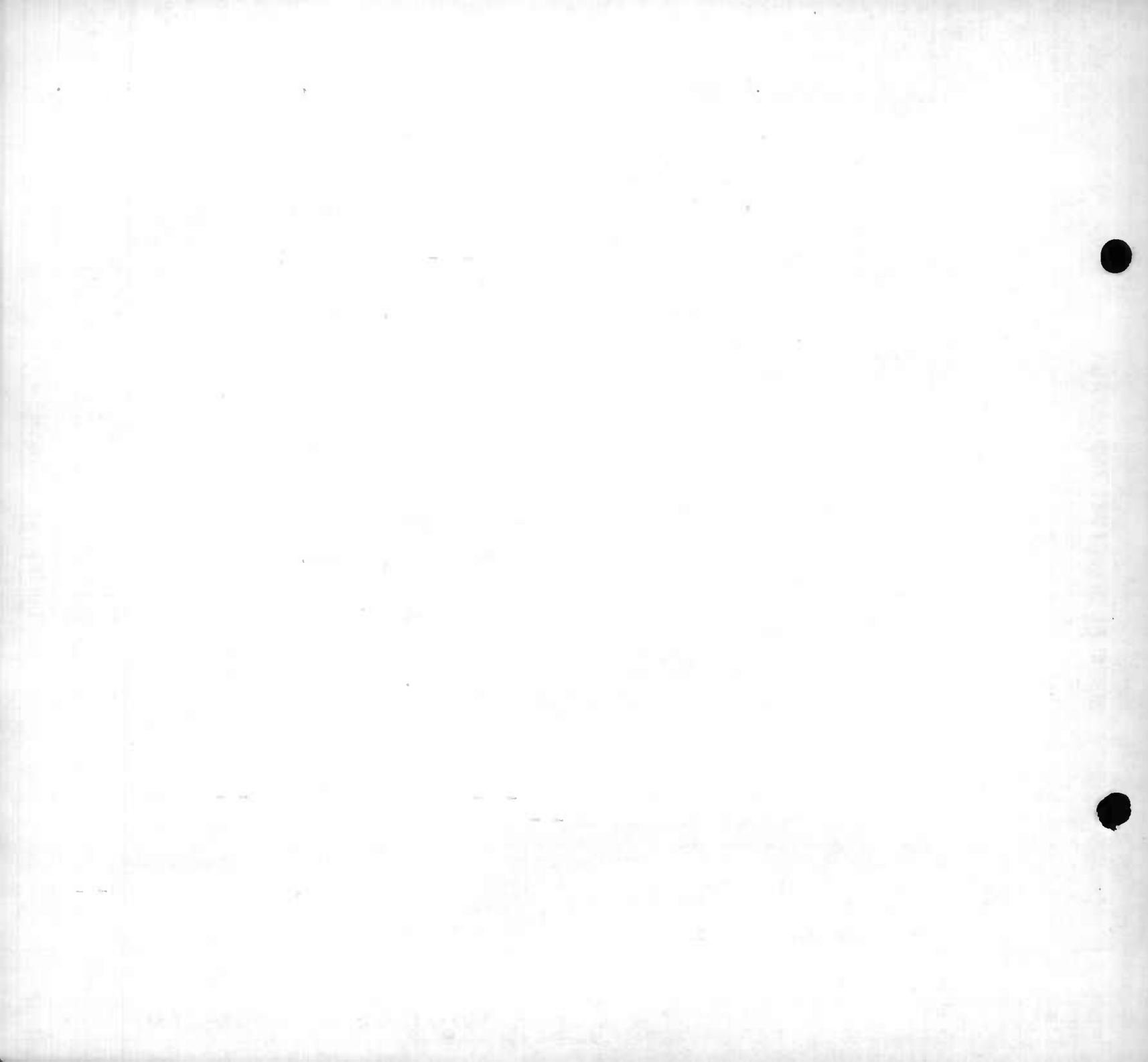
2. 1. 1900

2. 1. 1900

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3543</b>	
BIRTH NO. <b>65 3543</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Gladys Gilmore</b>		2. DATE AND HOUR OF DEATH <b>April 1, 1965 3:25 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital 1514 Division Street Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-01</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>926 Carrollton Avenue</b>	
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>11-29-25</b>
9. AGE (In years lost birthday) <b>37</b>		10. If Under 1 Yr. Months Days	11. If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jays Gilmore</b>		14. MOTHER'S MAIDEN NAME <b>Mabel</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-26-1438</b>	17. INFORMANT ADDRESS <b>Edward Gilmore 815 N. Futton Ave</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>75-7.31</b>		CAUSE OF DEATH (A) <b>Uremia</b> DUE TO (B) <b>Malignant Hypertension</b> DUE TO (C) <b>Ectopic kidney, Adenoma of left adrenal gland</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		<b>Congestive heart failure with pulmonary edema Bronchopneumonia</b>	
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes.</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3-12-1965</b> to <b>4-1-1965</b> , that (I) (we) last saw the deceased alive on <b>4-1-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ruperto Manankil</b>		23B. DATE SIGNED <b>Marc 4-2-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Ruperto Manankil</b>		23D. ADDRESS <b>M.D. 1514 Division Street</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rural</b>	24B. DATE <b>4/6/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cem</b>	24D. LOCATION (City, town, or county) (State) <b>Ann Arundel Cty., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	25C. FUNERAL DIRECTOR ADDRESS <b>918 Druid H. Ave.</b>	



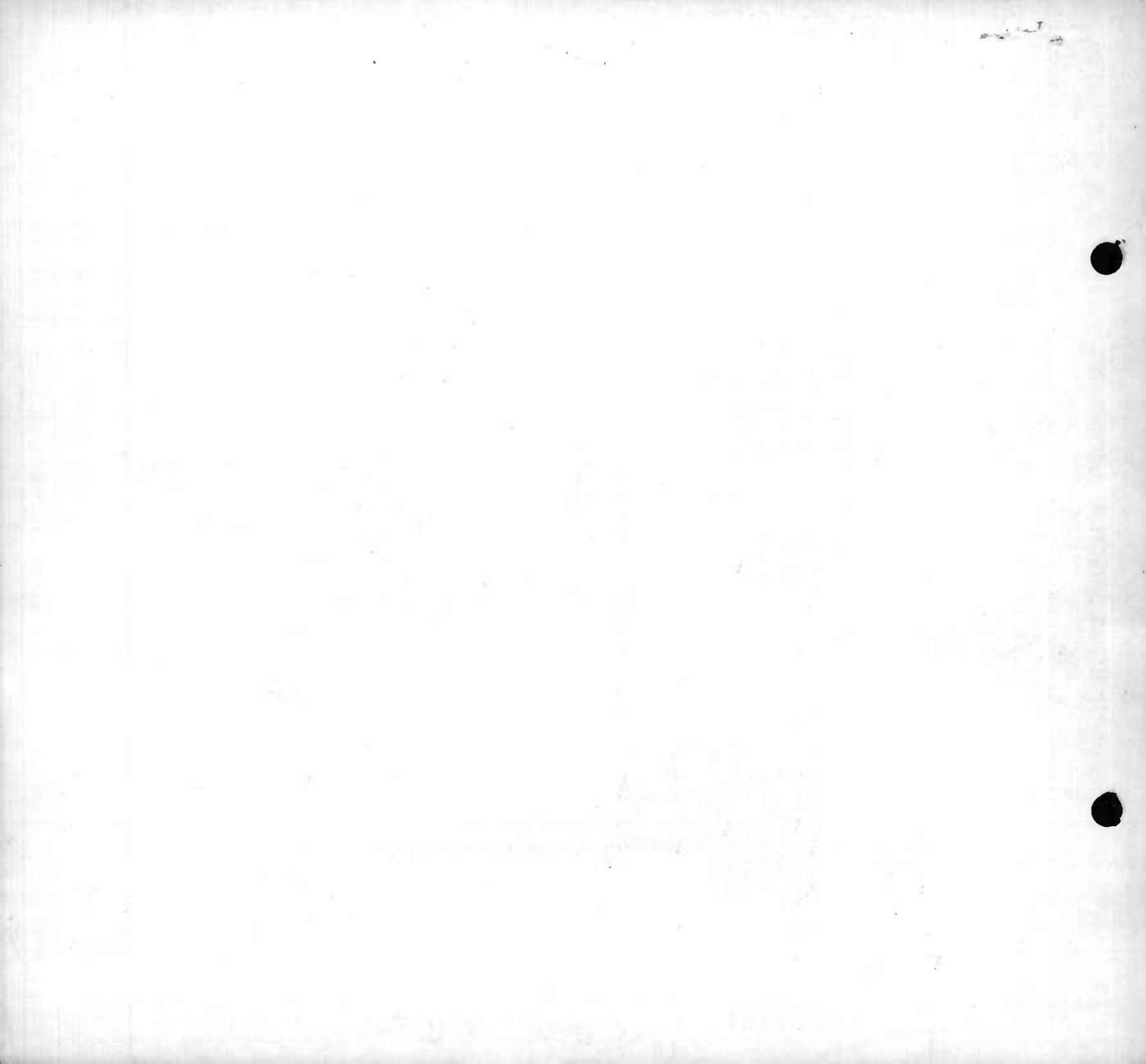


To Be Released by Medical Examiner

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

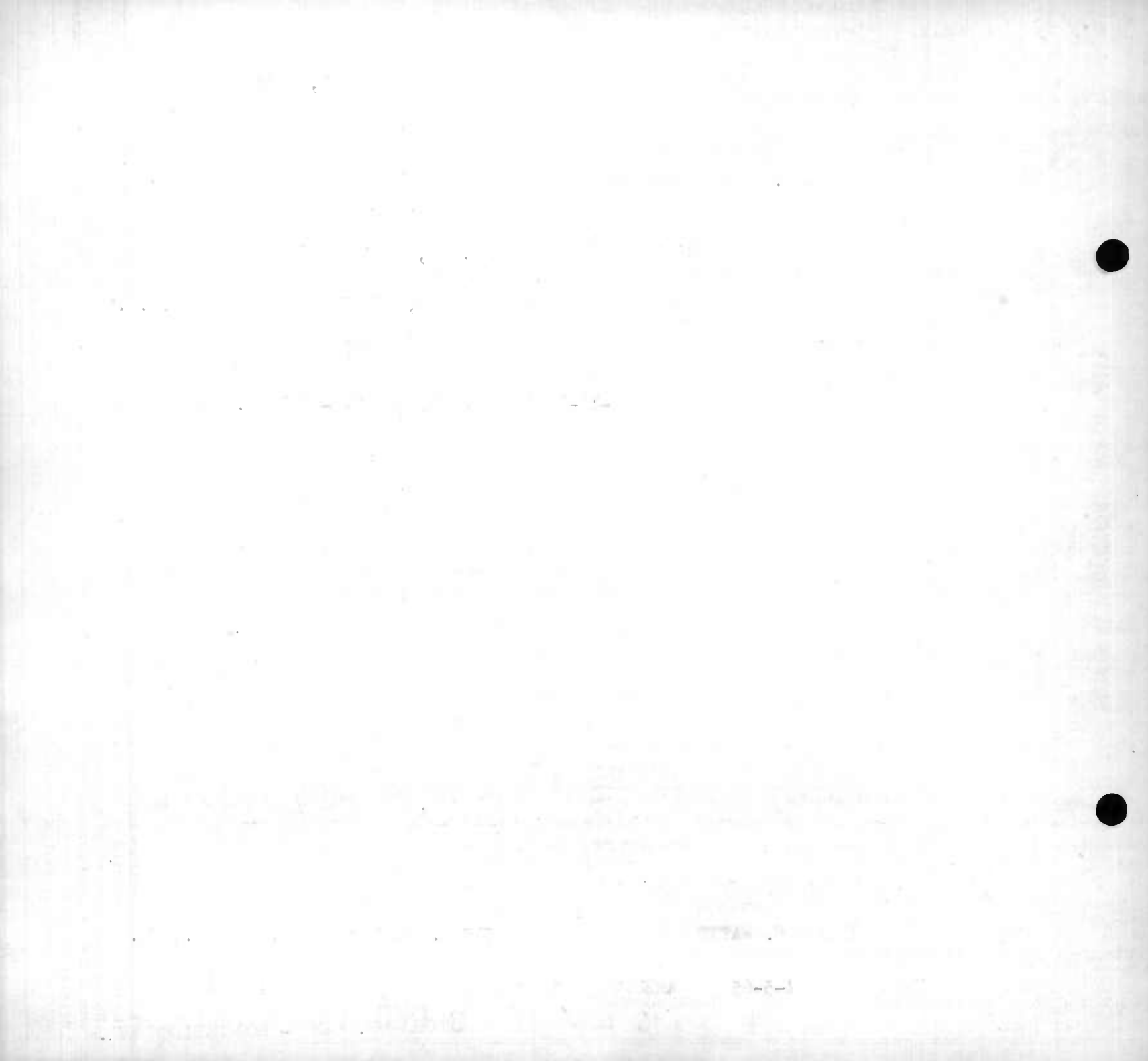
BIRTH NO. 65 3544		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3544	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		JOHNSON, Anton Lewis		2. DATE AND HOUR OF DEATH 4/2/65 9:30 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Md		B. COUNTY 13-02	
MARYLAND GENERAL HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		716 - RESERVOIR ST. #17	
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) N.M.	8. DATE OF BIRTH 10/29/58	9. AGE (In years lost birthday) 6	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME EDWARD JOHNSON		14. MOTHER'S MAIDEN NAME WAGSTAFF BERNADINE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Bernadine Johnson 716 Reservoir St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		798% 3rd degree Burns. - 34 hs.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO acute + diffuse airway obstruction + pneumonia... tracheo-bronchitis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		DUE TO Bronchial Asthma - Chicken Pox.			
19A. DATE OF OPERATION 4/1/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) yes		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home		21C. WHERE DID INJURY OCCUR? Baltimore 716 Reservoir Street	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) April 12/1965 11:30 AM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? 13-02 clothing caught fire from hot plate	
22. I certify that (I) (this hospital) attended the deceased from 4/1 to 4/2 and that (I) (we) last saw the deceased alive on 4/2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
22A. SIGNATURE Francesco M. Sanjoford M.D.				22B. DATE SIGNED 4/2/65	
23C. PHYSICIAN'S NAME (Type) FRANCESCO M. SANJOFORD M.D.				23D. ADDRESS University Hospital - Baltimore, Md	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/65		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery	
		24D. LOCATION (City, town, or county) Ann Arundel Cty., Md.		24E. STATE	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS 918 Druid Hill Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

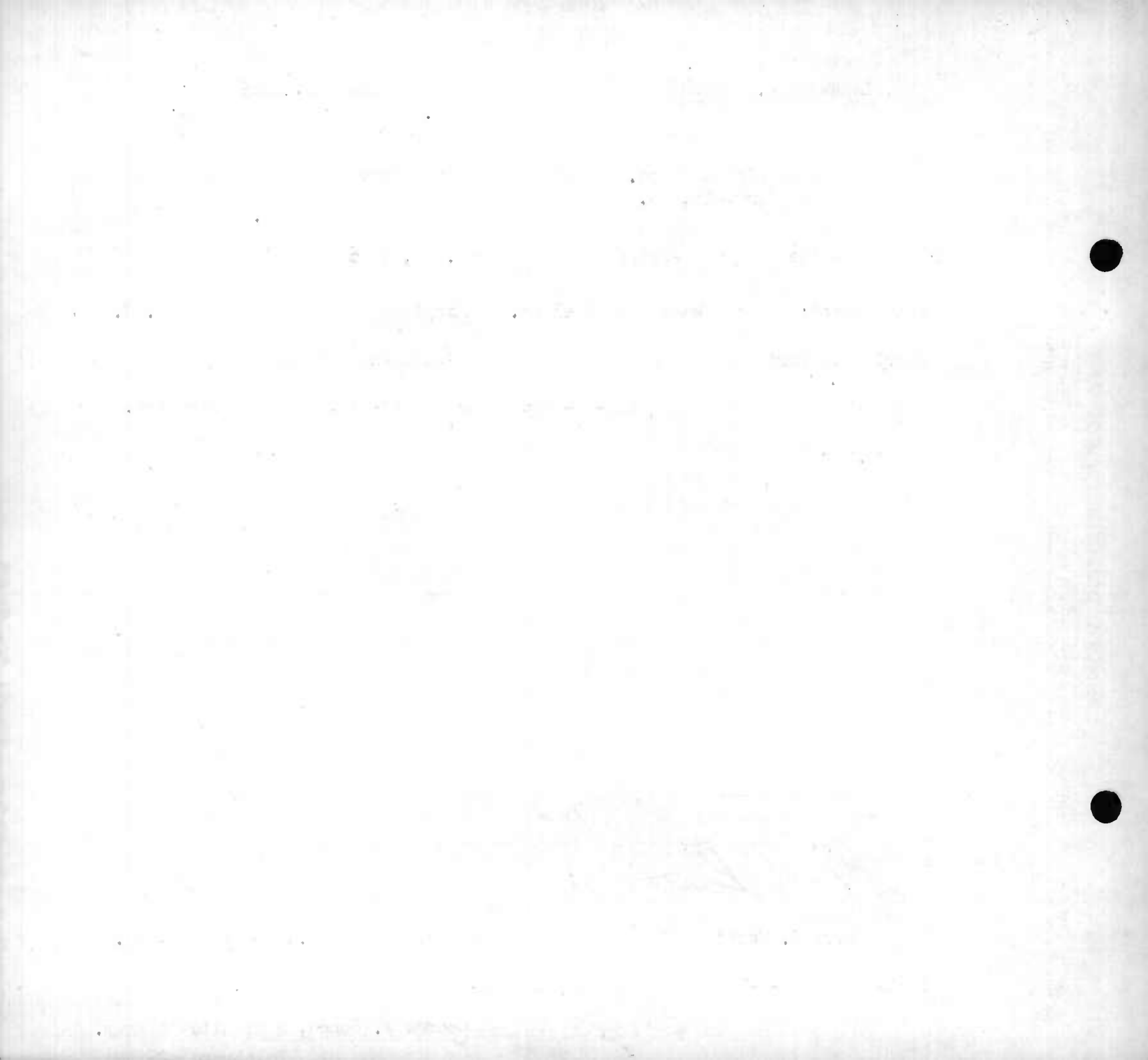
BIRTH NO. 65 3545		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3545	
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) ROBERT CUPITT			APRIL 1, 1965		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2812 W. NORTH AVENUE			A. STATE MARYLAND B. COUNTY 1506		
5. SEX MALE			6. RACE COLORED		
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED			8. DATE OF BIRTH AUG. 25, 1904		
9. AGE (In years last birthday) 60			10. CITIZEN OF WHAT COUNTRY? U.S.A.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10B. KIND OF BUSINESS OR INDUSTRY SMELTING & REFINING		
11. BIRTHPLACE (State or foreign country) WARSAW, VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOHN CUPITT			14. MOTHER'S MAIDEN NAME ROXANNE DAVIS		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO. 212-10-1044		
17. INFORMANT THELMA CUPITT - 2812 W. NORTH AVENUE			ADDRESS		
18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Myocardial infarction Sudden Anteroselective cardiovascular disease 8 years			INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Nov 15 1957 to April 1 1965, that (I) last saw the deceased alive on March 15 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE William H. Watts			23B. DATE SIGNED 4-5-65		
23C. PHYSICIAN'S NAME (Type) WILLIAM H. WATTS			23D. ADDRESS 515 N. ARLINGTON AVE., BALTO., MD.		
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-5-65		24C. NAME of CEMETERY or CREMATORY ARBUTUS MEMORIAL PARK	
24D. LOCATION BALTIMORE, MARYLAND		24E. DATE REC'D BY HEALTH DEPT. APR 5 1965		24F. NAME OF REGISTRAR Charles R. Law	
24G. DATE REC'D BY HEALTH DEPT. APR 5 1965		24H. NAME OF REGISTRAR Charles R. Law		24I. FUNERAL DIRECTOR CHARLES R. LAW - 802 MADISON AVE.	



FUNERAL DIRECTOR: IMPORTANT

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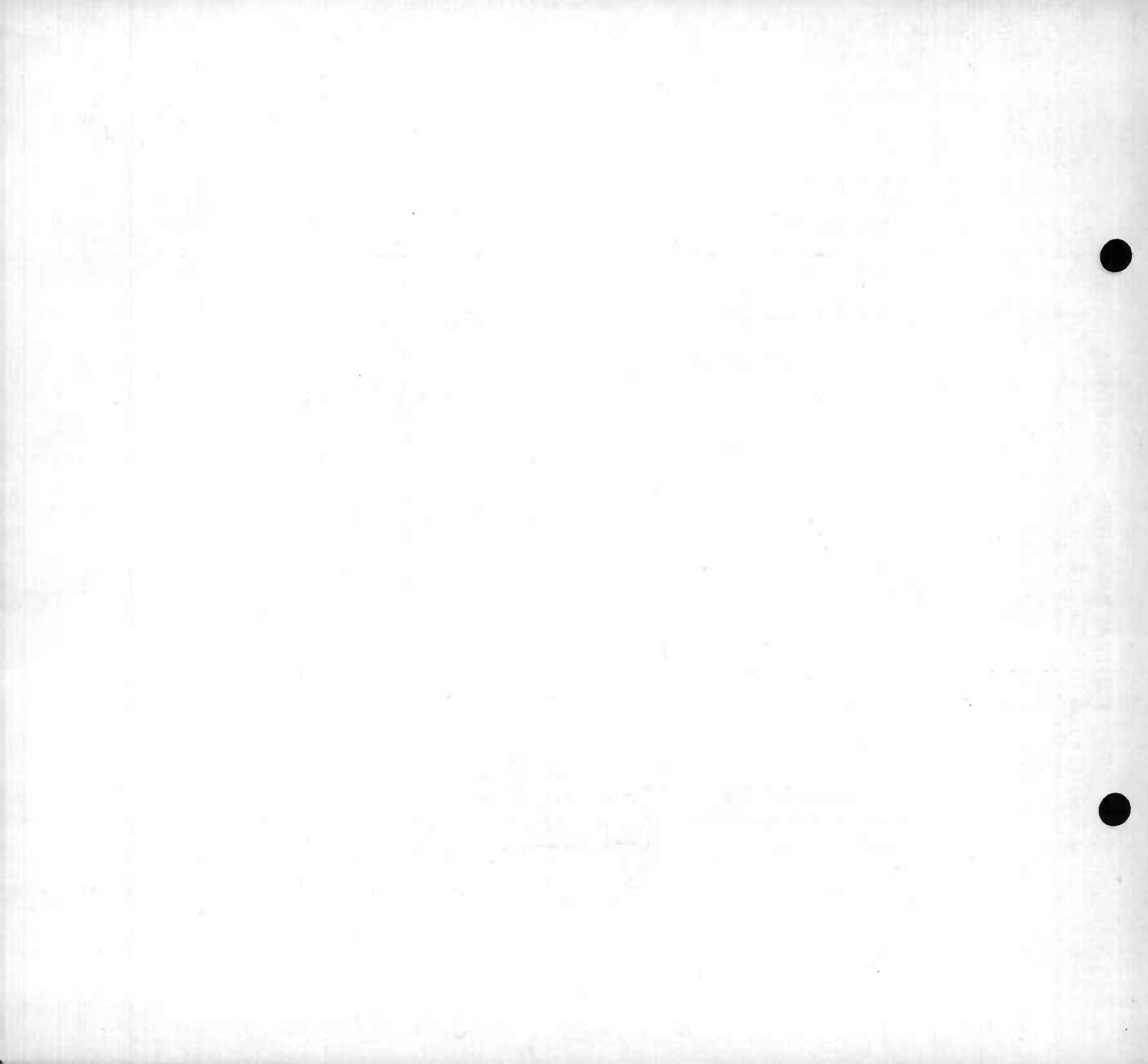
BIRTH NO. 65 3546				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3546	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LAWRENCE A. SEIFERT</b>				2. DATE AND HOUR OF DEATH <b>March 30, 1965 1 9:35 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2504</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>4105 Highland Ave. Baltimore 25, Md.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>4105 Highland Ave.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 20, 1896</b>	9. AGE (In years last birthday) <b>69</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crain Operator</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13. FATHER'S NAME <b>Charles Seifert</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Ziomek</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-05-7226</b>		17. INFORMANT ADDRESS <b>Marie Seifert, 4105 Highland Ave.</b>	
18. <b>177X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Ca of Prostate</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>c metastases</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD &amp; Cong Heart failure</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 22 19 60</b> to <b>Mar 30 19 65</b> , that (I) (we) last saw the deceased alive on <b>Mar 25 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Harry B. Scott</b> M.D.				23B. DATE SIGNED <b>4-1-65</b>		23C. PHYSICIAN'S NAME (Type) <b>Harry B. Scott</b>	
23D. ADDRESS <b>Medical Arts Bldg., Baltimore, Md.</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-1965</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Starker</b>		25C. FUNERAL DIRECTOR <b>George J. Gonce</b>		ADDRESS <b>4001 Ritchie Hwy. Baltimore 25 Md</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 3547					REGISTERED NO. 65 3547				
RIGHTER CERTIFICATE OF DEATH									
1. NAME OF DECEASED (Type or Print) <u>Charles Henry Richter</u>					2. DATE AND HOUR OF DEATH <u>3-31-65 4:20 P. M.</u>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION <u>University Hospital Baltimore, MD</u>					A. STATE <u>Maryland</u> B. COUNTY <u>27-01</u>				
					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>				
					D. STREET ADDRESS (If rural, give location) <u>4610 Bel Air Rd</u>				
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>		8. DATE OF BIRTH <u>3-9-09</u>	9. AGE (In years (last birthday)) <u>55</u>	10. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>					
13. FATHER'S NAME <u>Charles H. Richter</u>				14. MOTHER'S MAIDEN NAME <u>Maudie ?</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. —		17. INFORMANT <u>Pt's chart</u>		ADDRESS	
18. CAUSE OF DEATH									
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>230X I</u>					INTERVAL BETWEEN ONSET AND DEATH <u>Nov 64 → 3/31</u>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) <u>Nephroses</u> (B) <u>Retroperitoneal Tumor 11-64 → 3/31/65</u> (C) —				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <u>Nov 1964</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Retroperitoneal Mass</u>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (1) (this hospital) attended the deceased from <u>March 22 1965</u> to <u>March 31 1965</u> . that (1) <del>was</del> last saw the deceased alive on <u>March 31 1965</u> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>was</del> <del>(not)</del> view the body after death.									
23A. SIGNATURE <u>Louis C. Breschi</u>					M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3-31-65</u>		
23C. PHYSICIAN'S NAME (Type) <u>Louis C. Breschi</u>					23D. ADDRESS <u>University Hospital</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-2-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. ...</u>		25C. FUNERAL DIRECTOR <u>Ulrich Funeral Home</u>		ADDRESS <u>Baltimore, Md.</u>			

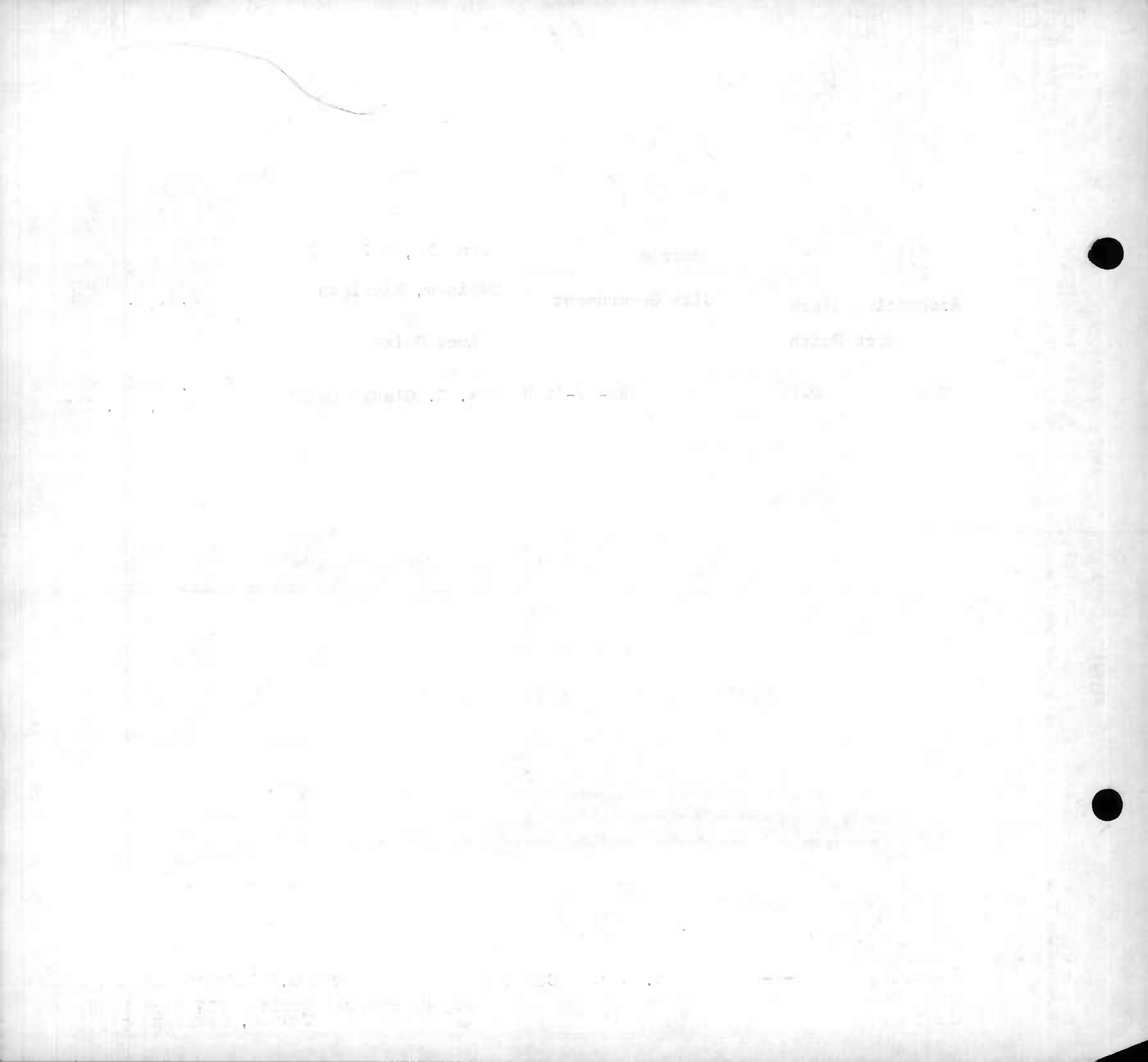




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

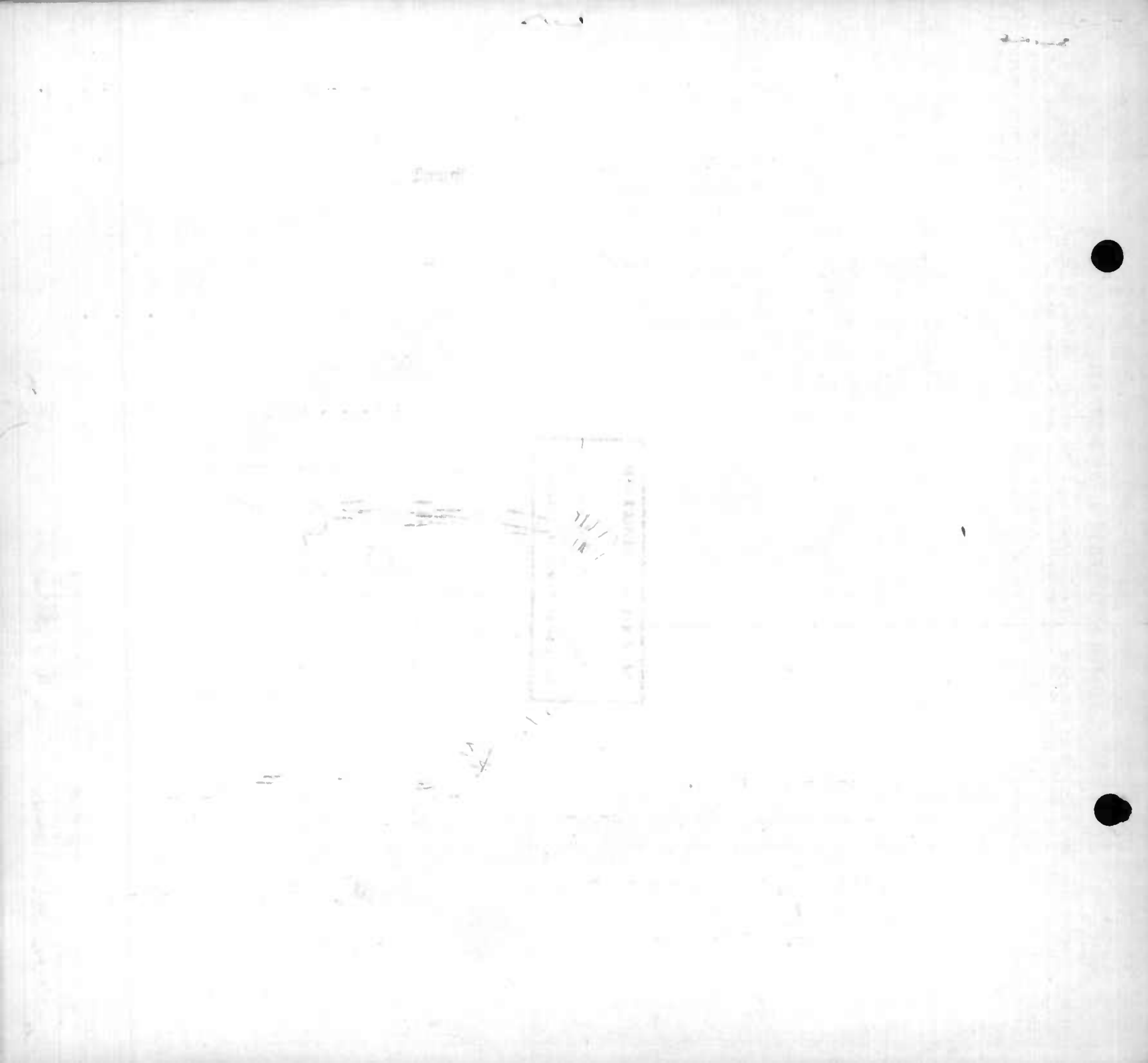
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 3548</u>	
BIRTH NO. <u>65 3548</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Walter Smith</u>		2. DATE AND HOUR OF DEATH <u>3-30-65</u>   <u>7 30</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>37 Mercy Hospital.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>md.</u> B. COUNTY <u>BALTO</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> <u>53-00</u>	
		D. STREET ADDRESS (If rural, give location) <u>7825 E. BALTO. ST</u>			
5. SEX <u>M.</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>June 27, 1917</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>City Government</u>		11. BIRTHPLACE (State or foreign country) <u>Saginaw, Michigan</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>		13. FATHER'S NAME <u>Bert Smith</u>		14. MOTHER'S MAIDEN NAME <u>Lucy Smith</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWII</u>		16. SOCIAL SECURITY NO. <u>380-09-9249</u>		17. INFORMANT <u>Mrs. E. Gladys Smith</u>	
		ADDRESS <u>7825 E. Baltimore Street</u> <u>Baltimore, Md. 21224</u>			
18. <u>420.11</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Myocardial Infarction</u> DUE TO (B) <u>Coronary Occlusion</u> DUE TO (C) <u>Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-12</u> 19 <u>65</u> to <u>3-30</u> 19 <u>65</u> , that (I)-(we) last saw the deceased alive on <u>3-30</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Donald A. Deinlein</u> M.D.				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>Donald A. Deinlein</u> M.D.				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-2-1965</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Carmel Cemetery</u>	
		24D. LOCATION (City, town, or county) (State) <u>Parkton, Baltimore County, Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1965</u>		25B. NAME OF REGISTRAR <u>R. E. ...</u>		25C. FUNERAL DIRECTOR <u>Brooks Funeral Service</u> 622 York Road <u>Towson, Maryland 21204</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

43-01-22 5-345		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3549	
BIRTH NO. 65 3549		CÉRTIFICÁTE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Anna Stalnaker		3-30-65 9:20 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224		Maryland, Baltimore			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Rural 53-00			
		D. STREET ADDRESS (If rural, give location)			
		7531 Eastern Avenue			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	White	Married	8-31-1911	53	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
		At Home		Pennsylvania	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
George D. Paderson		Anna C. ?		U. S. A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				RECORDS: B.C.H. 4940 Eastern Avenue #21224	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
E416X1 Pneumatic Heart Disease		Trauma, ? Fall			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2		Yes	Yes		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
	Home				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
3-30-65 8:00 A.		3 Fell while Cleaning			
22. I certify that (I) (this hospital) attended the deceased from 3-30-19 65 to 3-30-19 65, that (I) (we) last saw the deceased alive on 3-30-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Dr. Philip Zieve		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 3-30-65	
23C. PHYSICIAN'S NAME (Type) Dr. Philip Zieve		23D. ADDRESS 4940 Eastern Avenue #21224			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE 4-2-65	24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR Robert E. Feltner		25C. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home Balto., Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3550		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3550	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HALE, RUSSELL S.			2. DATE AND HOUR OF DEATH 4-1-65 11:30P.M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION ST. AGNES HOSPITAL			A. STATE MARYLAND		
(If not in hospital or institution, give street address or location)			B. COUNTY		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE		
			D. STREET ADDRESS (If rural, give location) 500E LYNN STREET		
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 12-30-03	9. AGE (In years last birthday) 61	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher		10B. KIND OF BUSINESS OR INDUSTRY Meat		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME James H. Hale		14. MOTHER'S MAIDEN NAME Florence A. Rhodes		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, No unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 215-09-9525		17. INFORMANT ST. AGNES RECORDS--CATON & WILKENS AVES	
18. 5-81,01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) Pneumonia DUE TO (B) Cirrhosis of Liver DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from MARCH 18 19 65 to APRIL 1 1965, that (I) (we) lost saw the deceased alive on APRIL 1 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Raphael C. Myers Jr.			23B. DATE SIGNED April 2, 1965		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/65		24C. NAME OF CEMETERY or CREMATORY Mt Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR R. E. S. S.		25C. FUNERAL DIRECTOR W. H. F. Funeral Home Pratt & Stueker Inc	

1977-1978

1979-1980

1981-1982

1983-1984

1985-1986

1987-1988

1989-1990

1991-1992

1993-1994

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2003-2004

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2011-2012

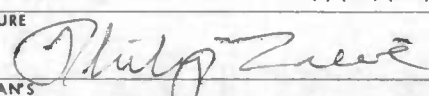
2013-2014

2015-2016

2017-2018

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3551</b>	
BIRTH NO. <b>65 3551</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>March 30, 1965   3:30 P. M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Roy Dennison</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>	
5. SEX <b>Male</b>		6. RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>		8. DATE OF BIRTH <b>11-7-1907</b>	
9. AGE (In years last birthday) <b>57</b>		10. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Harford</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Dennison</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-09-5569</b>	
17. INFORMANT <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma Lung Metastatic</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 6, 1965</b> to <b>March 30, 1965</b> , that (I) (we) last saw the deceased alive on <b>March 30, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE  Philip Zieve		23B. DATE SIGNED <b>March 30, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Philip Zieve</b>		23D. ADDRESS <b>4940 Eastern Avenue 21224</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Apr. 3, 1965</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cokesbury Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Abingdon, Harford, Maryland.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>Howard K. Mc Comas &amp; Son, Abingdon, Md.</b>	
25C. FUNERAL DIRECTOR <b>Howard K. Mc Comas &amp; Son, Abingdon, Md.</b>		ADDRESS	

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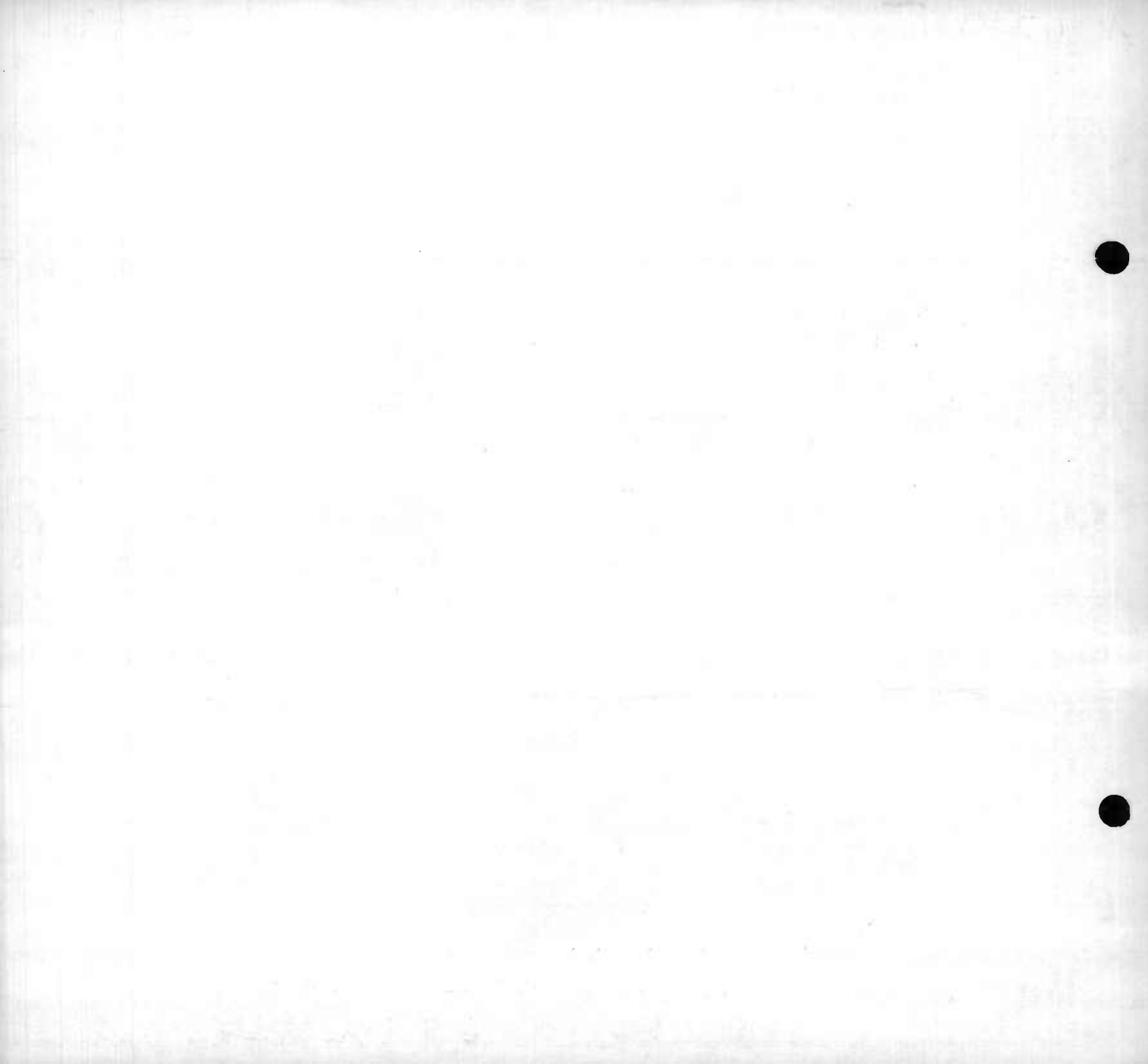
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3552				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3552	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Norris, Clara				2. DATE AND HOUR OF DEATH 4/2/65 11:40 am M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Johns Hopkins Hospital				A. STATE B. COUNTY Maryland 13-06			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 3302 Elm Ave			
5. SEX F	6. RACE Cauc	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 1/24/24	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM GRAPE		14. MOTHER'S MAIDEN NAME EMMA					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 288-12-9046		17. INFORMANT ADDRESS WALTER C. NORRIS 3302 ELM AVE			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO (B) DUE TO (C) Mitral Stenosis 3 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Emphysema							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (as physician) attended the deceased from 3/21 1965 to 4/2 1965, that (I) (as) last saw the deceased alive on 4/1 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE John F. Bigger, Jr., M.D.				23B. DATE SIGNED 4/2/65			
23C. PHYSICIAN'S NAME (Type) John F. Bigger, Jr., M.D.				23D. ADDRESS Johns Hopkins Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-5-65		24C. NAME OF CEMETERY or CREMATORY BALTO. NAT. Cem.		24D. LOCATION (City, town, or county) (State) BALTO. MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR Paul E. Chenoweth		25C. FUNERAL DIRECTOR Paul E. Chenoweth		ADDRESS 3302 Elm Ave	



1  
G. 432

65 3553

BALTIMORE CITY HEALTH DEPARTMENT

65 3553

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BERNICE K. GOLDSBOROUGH

2. DATE AND HOUR PRONOUNCED DEAD

4/2/65 2:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

City Hospitals

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland

B. COUNTY

Balto

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

7520 Carroll Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

July 22, 1923

9. AGE (In years last birthday)

41

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Labeller

10B. KIND OF BUSINESS OR INDUSTRY

Bennett Foods

11. BIRTHPLACE (State or foreign country)

Glen Burnie, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Digby Whitmore

14. MOTHER'S MAIDEN NAME

Eva Gumpman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

216-14-8448

17. INFORMANT

Elizabeth M. Goldsborough

ADDRESS

7520 Carroll Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Exsanguination

(A) DUE TO transection of aorta caused by blunt force injury to the chest

(B) DUE TO

(C)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Old North Point Rd.

21D. TIME OF INJURY (APPROX.)

4 2 65 2:05 a.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

passenger in auto which struck culvert

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/2/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

4-6-1965

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 5 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Lilly & Zeiler Inc.

ADDRESS

1901 Eastern Ave.

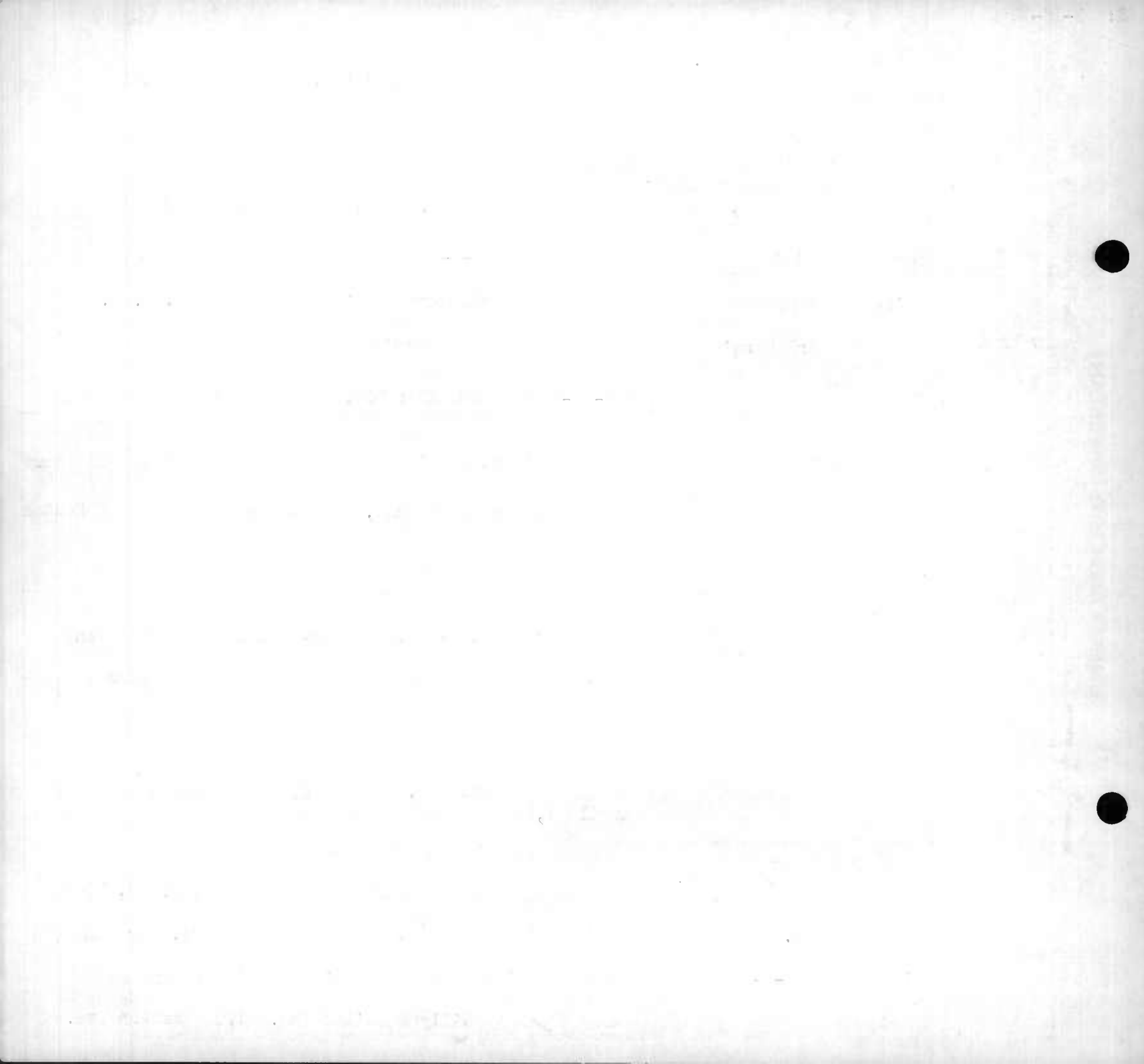
WALLEY FIDRGE

2/1/12

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

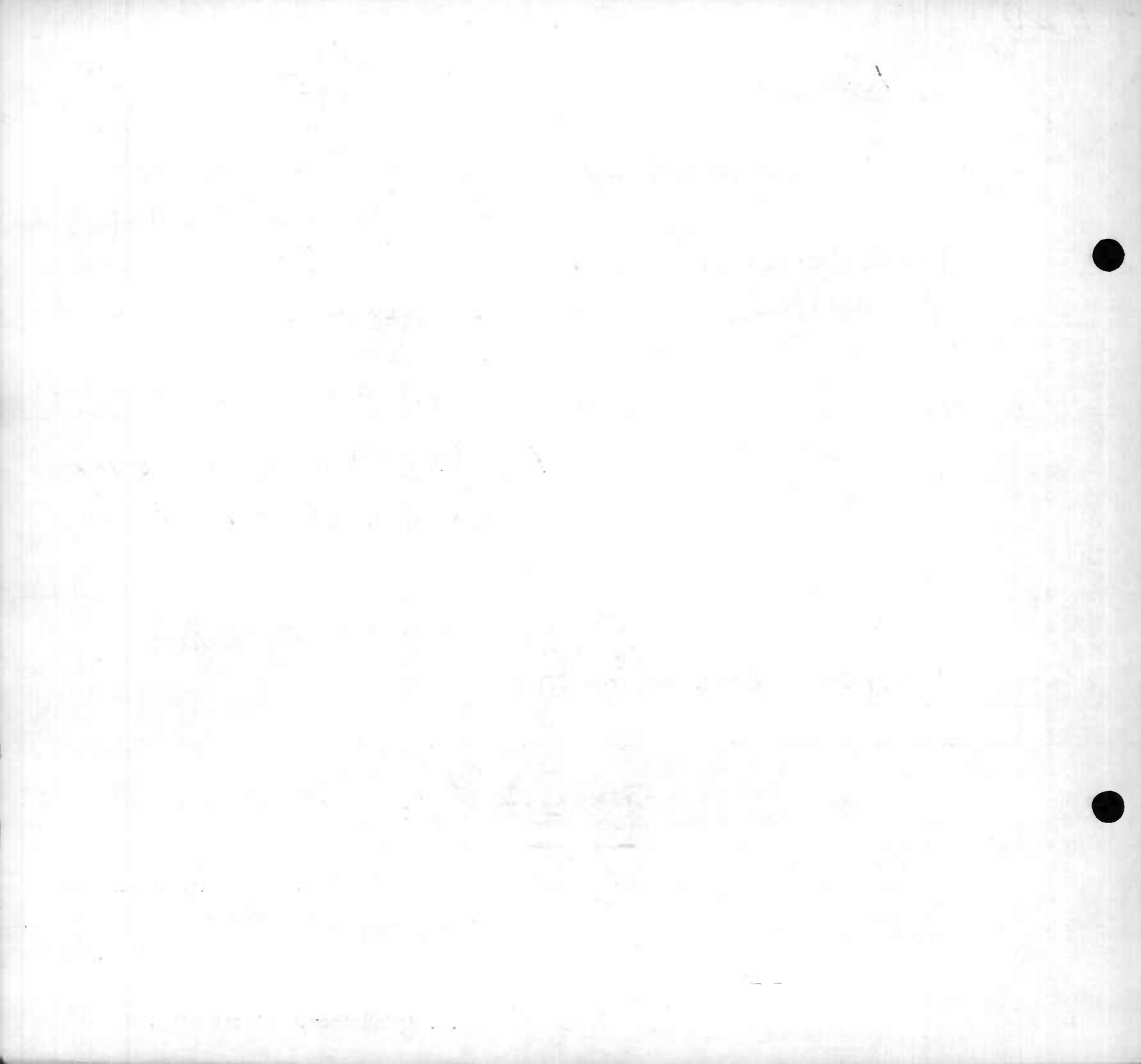
LS: 43-18-32-1		BIRTH NO. 65 3554		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3554	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) B. Arthur Hornig				2. DATE AND HOUR OF DEATH April 3, 1965 4:00 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				A. STATE Maryland B. COUNTY Baltimore			
5. SEX Male				6. RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	
8. DATE OF BIRTH 9-8-94		9. AGE (In years last birthday) 70		10. CITIZEN OF WHAT COUNTRY? U. S. A.		11. BIRTHPLACE (State or foreign country) Germany	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME Karl Hornig				14. MOTHER'S MAIDEN NAME Martha ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-05-2777		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224			
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Pneumonia DUE TO				24 Hours			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Carcinoma of Lung, Metastatic DUE TO				5 Months			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Arteriosclerotic Cardiovascular Disease				Years			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 26, 19 65 to April 3, 19 65, that (I) (we) last saw the deceased alive on April 3, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Dr. Charles Carpenter				23B. DATE SIGNED April 3, 1965		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) Dr. Charles Carpenter				23D. ADDRESS 4940 Eastern Avenue Baltimore, Maryland #24			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-1965		24C. NAME of CEMETERY or CREMATORY Moreland Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS Lilly & Zeiler Inc. 1901 Eastern Ave.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3555				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3555	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>RALLS, MYRA MAY</b>				2. DATE AND HOUR OF DEATH <b>4/2/65 2:50 PM</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hosp.</b>		(If not in hospital or institution, give street address or location)		A. STATE <b>Md.</b>		B. COUNTY <b>HOWARD</b>	
C. CITY OR TOWN <b>Balto.</b>		(If outside city limits, write RURAL and give township)		D. STREET ADDRESS <b>Spring Grove State Hosp.</b>		(If rural, give location)	
5. SEX <b>Female</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b>	8. DATE OF BIRTH <b>1/13/91</b>	9. AGE (In years lost birthday) <b>74</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>William Terry CAREY</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Boyer</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Wilbert A. Ralls, son,</b>	
18. <b>6-20-51</b>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO <b>Aspiration Pneumonitis</b>		<b>6 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO <b>Intestinal Obstruction</b>		<b>10 days</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>ASCVD - congestive heart failure</b>			
19A. DATE OF OPERATION <b>3/27/65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Intestinal Obstruction</b>		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>April 1, 1965</b> to <b>April 2, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 2, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Carl F. Berner</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>CARL F. BERNER,</b>				23D. ADDRESS <b>University Hosp.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Crest Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>West Friendship, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley</b>		25C. FUNERAL DIRECTOR <b>F. C. Higginbotham, Jr.</b>			
				ADDRESS <b>Ellicott City, Md</b>			

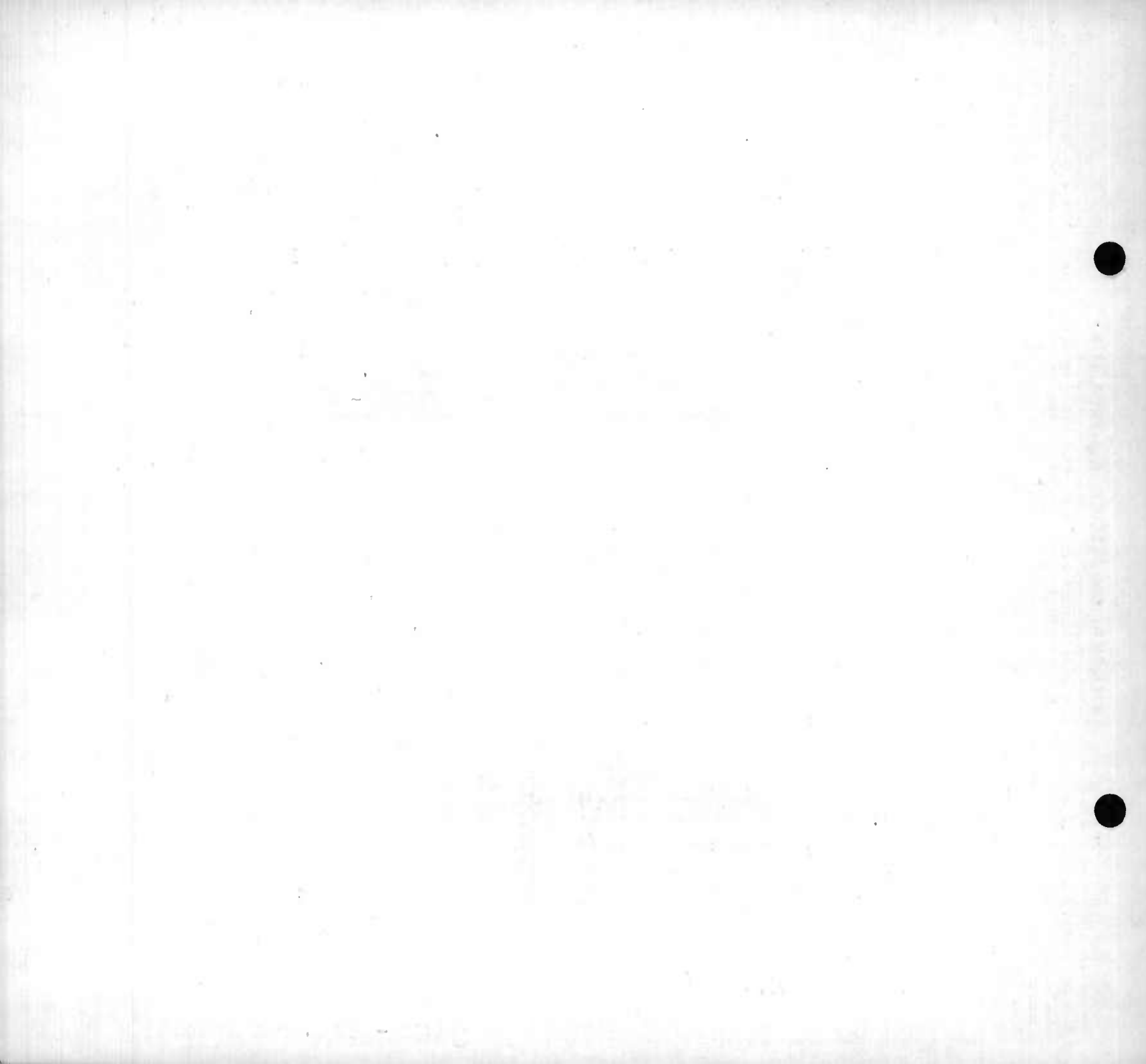




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

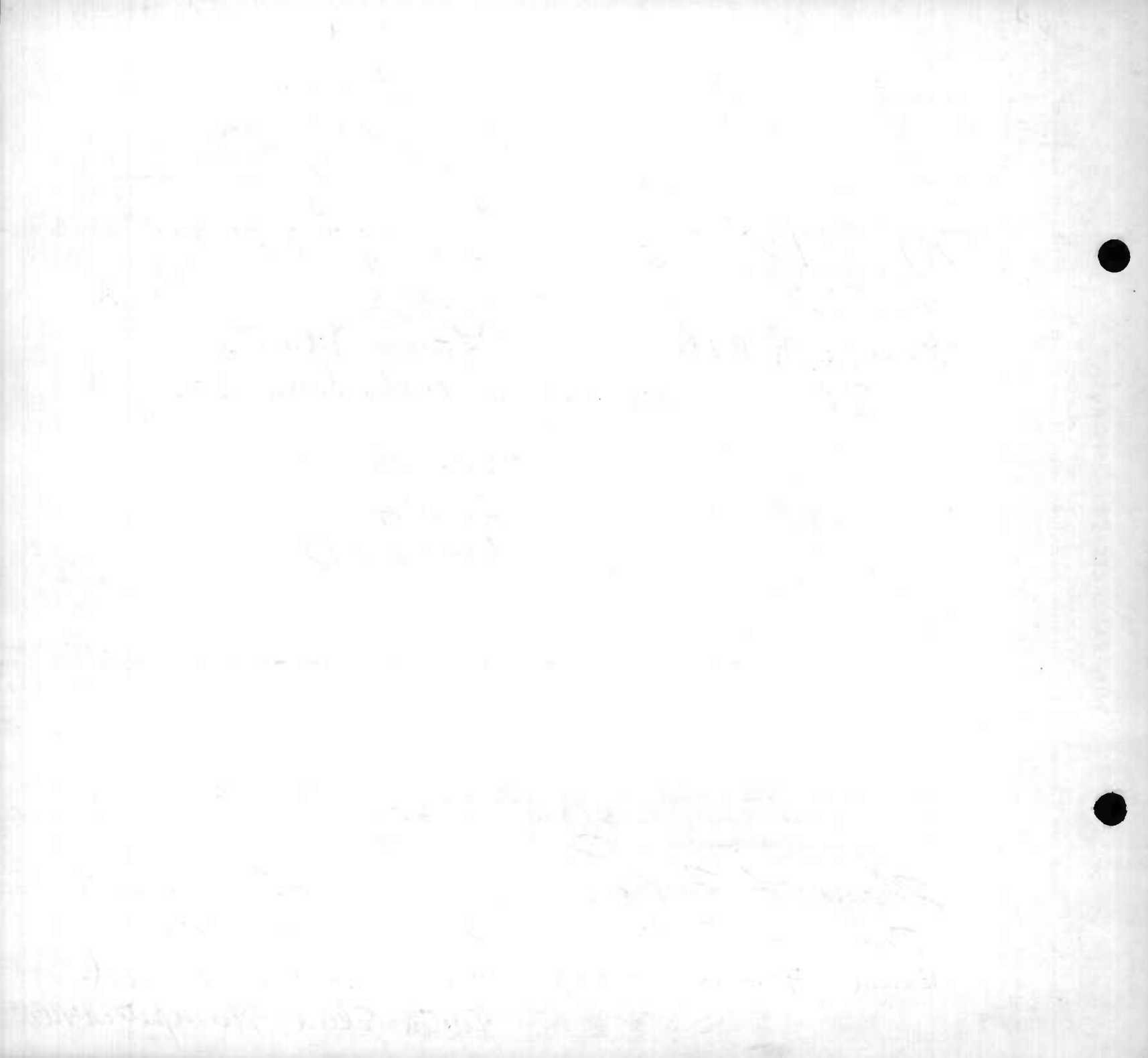
BIRTH NO. <span style="font-size: 2em;">65 3556</span>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <span style="font-size: 2em;">65 3556</span>	
<b>CERTIFICATE OF DEATH</b>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">SARAH ANNE GIBBS</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4/1/65</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <span style="font-size: 1.2em;">ST. AGNES</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD.</span> B. COUNTY <span style="font-size: 1.2em;">Balt</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">LANSDOWNE</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">53-00</span> <span style="font-size: 1.2em;">32 THIRD AVENUE</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">M</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">9/19/81</span>	9. AGE (in years last birthday) <span style="font-size: 1.2em;">83</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">NONE</span>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">VIRGINIA</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U S A</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">DOUGLASS</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">?</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">FAMILY - SAME</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			19. CAUSE OF DEATH (A) DUE TO <span style="font-size: 1.2em;">Intercerebral C.V.D</span> (B) DUE TO (C)		
20. INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">10 years</span>			21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		
22. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		23. CONDITION FOR WHICH OPERATION WAS PERFORMED		24. AUTOPSY? (Yes or No)	
25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		29. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		30. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
31. HOW DID INJURY OCCUR?		32. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Jan 10</span> 19 <span style="font-size: 1.2em;">60</span> to <span style="font-size: 1.2em;">3/12</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">3/12</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
33. SIGNATURE <span style="font-size: 1.2em;">Paul Schmied</span>		34. DATE SIGNED <span style="font-size: 1.2em;">4/1/65</span>		35. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Paul Schmied</span>	
36. ADDRESS <span style="font-size: 1.2em;">2301 Annapolis Rd</span>		37. BURIAL, CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">B</span>			
38. DATE <span style="font-size: 1.2em;">4/3/65</span>		39. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">GLEN HAVEN</span>		40. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTIMORE</span>	
41. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 5 1965</span>		42. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. ...</span>		43. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">MCULLY 6 130 E. FORT AVENUE</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3557		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3557	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Leonard R Cole</i>		2. DATE AND HOUR OF DEATH <i>3/30/65</i> <i>805 P.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		5. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Sinai Hospital of Baltimore</i>		A. STATE <i>md.</i> B. COUNTY <i>Balto. Co.</i>		C. CITY OR TOWN <i>Butler, Md.</i> <i>53-00</i>	
(If not in hospital or institution, give street address or location)		D. STREET ADDRESS (If rural, give location) <i>Not on record</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Single</i>	8. DATE OF BIRTH <i>6/25/94</i>	9. AGE (In years lost birthday) <i>70</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>US</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George R Cole</i>		14. MOTHER'S MAIDEN NAME <i>Laura Martin</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>220-34-6595</i>		17. INFORMANT ADDRESS <i>Mrs Cecilia Laubke - Butler Md</i>	
18. <i>443X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>II</i> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <i>Aspiration Pneumonia</i> DUE TO (B) <i>C.V.A.</i> DUE TO (C) <i>HASCD</i>		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/26</i> 19 <i>65</i> to <i>3/30</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>3/30</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did) (did not) view the body after death.					
23A. SIGNATURE <i>Thomas L. Feher</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/30/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Thomas L. Feher</i>		23D. ADDRESS <i>Sinai Hospital of Balto. Inc</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-2-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Palmer Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto Co Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 5 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Ripton-Elgie Hempstead Md</i>			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

John NICHOLAS HECKL

2. DATE AND HOUR PRONOUNCED DEAD

March 30, 1965 2:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Baltimore & Ohio Railroad Yard  
Stricker & Cole Streets

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

337 S. Gilmer Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SEPARATED

8. DATE OF BIRTH

3-26-1887

9. AGE (In years  
last birthday)

78

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

RETIRED

10B. KIND OF BUSINESS OR INDUSTRY

GAS. &amp; ELEC. CO.

11. BIRTHPLACE (State or foreign country)

HUNGARY

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NICHOLAS HECKL

14. MOTHER'S MAIDEN NAME

ELIZABETH

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-05-4518

17. INFORMANT

(SISTER)

ADDRESS

MRS. ELIZABETH FAYES

337 S. GILMER ST.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Exsanguination  
DUE TO stab wound of neck

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Railroad yard

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Found: B&O RR Yard  
Stricker & Cole Streets21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

Found: 3 30 65 11:00

21E. INJURY OCCURRED

A. WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

Apparently stabbed self in neck

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☒ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-30-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-3-65

23C. NAME OF CEMETERY or CREMATORY

MT. OLIVET

23D. LOCATION

(City, town, or county)

BALTO., MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 5, 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

WITBEKE FUNERAL DIR. - 4101 EDMONDSON AVE

ADDRESS

WILLY'S FORD

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES R. CHAMBERS

2. DATE AND HOUR PRONOUNCED DEAD

4/2/65

1:25 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1903 Forrest Park Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 24, 1937

9. AGE (In years  
last birthday)

27

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Installer

10B. KIND OF BUSINESS OR INDUSTRY

C. &amp; P. Telephone Co. Balto. Md.

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Austin Chambers

14. MOTHER'S MAIDEN NAME

Margaret Mitchell

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

213 34 9608

17. INFORMANT

ADDRESS

Mrs. Kathleen Chambers, 1903 N. Forest Pk

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Transection of aorta with left hemothorax

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Engleside Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 2 65 12:58a

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒21F. HOW DID INJURY OCCUR? subject was driver  
of car which struck pole

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

W. U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/2/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/5/65

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

Baltimore Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 5 1965

Robert E. Taylor, M.D.

Witzke F.D. 4101 Edmondson Ave







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

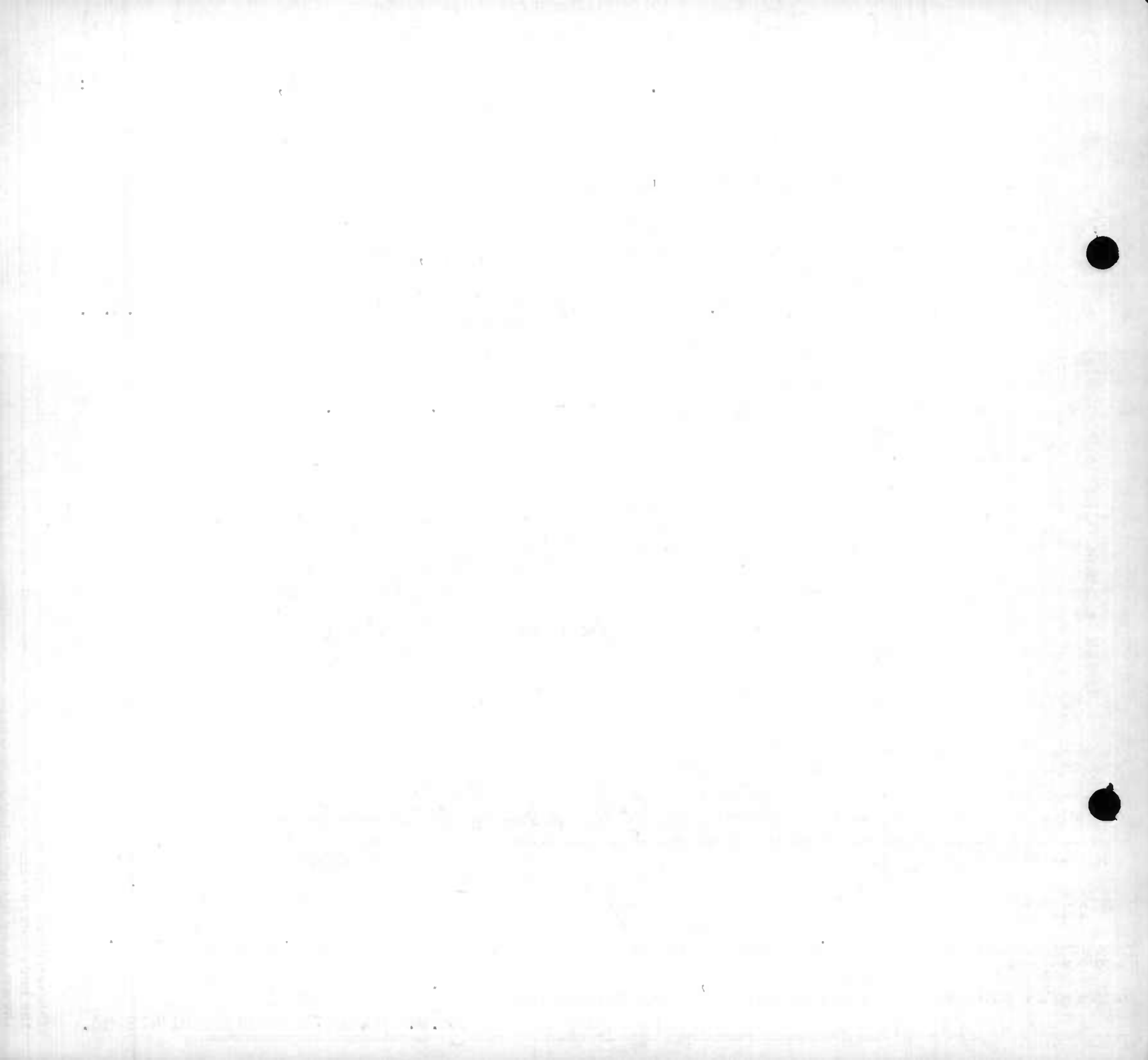
BIRTH NO. 65 3560		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3560	
M.E. CASE NO.		CERTIFICATE OF DEATH		DATE AND HOUR OF DEATH 2 Feb. 65 4/2/65 6:04 A.M.	
1. NAME OF DECEASED (Type or Print) J. Frank Schofield		2. DATE AND HOUR OF DEATH		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION Fayette Convalescent Home Fayette Nursing Home, E. Fayette St		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Ma. B. COUNTY Balto		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300	
5. SEX Male		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY GLASS CO.		8. DATE OF BIRTH 10 July, 1884	
13. FATHER'S NAME Joseph Schofield		14. MOTHER'S MAIDEN NAME Unknown ANNA (McVEY)		9. AGE (In years last birthday) 80	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 329-074568		11. BIRTHPLACE (State or foreign country) OHIO	
17. INFORMANT (Son) Anacortes, Washington		18. CAUSE OF DEATH		12. CITIZEN OF WHAT COUNTRY? USA	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) Branch pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5d	
ANTECEDENT CAUSES		(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 13 Sep 1964 to 2 Apr 1965, that (I) (we) last saw the deceased alive on 2 Apr 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE J. Hullia		23B. DATE SIGNED 2 Apr 65	
23C. PHYSICIAN'S NAME (Type) J. Hullia		23D. ADDRESS 2214 E Fayette St Balt Md 21231			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 4/4/65		24C. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	
24D. LOCATION (City, town, or county) Glendale, Arizona.		24E. STATE (State) Arizona.			
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR Robert E. J. J. J.		25C. FUNERAL DIRECTOR Witzke R.D. 4101 Edmondson Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 3561	
BIRTH NO. 65 3561		CERTIFICATE OF DEATH		Registered No. 65 3561	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		ALEXANDER J. KATZSCO		APRIL 1, 1965 1:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		A. STATE B. COUNTY	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		MARYLAND ANNE ARUNDEL		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
SOUTH BALTIMORE GEN'L HOSPITAL		GLEN BURNIE		D. STREET ADDRESS (If rural, give location)	
		107 CHAIN O HILL ROAD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	If Under 1 Yr. Months; Days (If Under 24 Hrs. Hours; Min.
MALE	WHITE	MARRIED	MAY 12, 1915	49	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
QUARTER MASTER DEPT. CIVIL SERVICE				MARYLAND U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
(UNKNOWN) KATZSCO		UNKNOWN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO X		217-09-3828		MRS. AGNES L. KATZSCO	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO Myocardial infarction? - DUA		35 min?	
ANTECEDENT CAUSES		(B) DUE TO old anteurial. & old post a.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Coronary artery Disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Laennec's cirrhosis?			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
O		NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-19-65 to 4-1-65 that (I) (we) last saw the deceased alive on 3-12-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
DR. FRANK SHIPLEY				4-3-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		121 CATHEDRAL ST. ANNAPOLIS, MD.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
BURIAL	APRIL 5, 1965	CEDAR HILL CEM.	BROOKLYN RFD MARYLAND		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS			
APR 5 1965	Robert E. Taylor, M.D.	R.V. SINGLETON GLEN BURNIE MO.			



BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
5. 152		65 3562		65 3562			
M.E. CASE NO.				2. DATE AND HOUR PRONOUNCED DEAD			
1. NAME OF DECEASED (Type or Print)				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
CECILIA SPENCER				A. STATE Maryland			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)			
Provident Hospital				Baltimore			
D. STREET ADDRESS (If rural, give location)				2271 Reisterstown Rd.			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
female	colored	Never married	6-15-14	50			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Domestic				VA.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO						Constance Bailey 1438 Argle Ave	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Multiple injuries			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN VERIFYING CAUSES OF DEATH?	
2				yes		yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		street		Reisterstown Rd. and Lynnbrook Ave.			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		pedestrian struck by car			
4 1 65 7:53 p							
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER			
W.H. Spitz, M.D.				ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23A. BURIAL CREMATION, REMOVAL (Specify)				23B. DATE		23C. NAME OF CEMETERY or CREMATORY	
Burial				4-6-65		Arbutus Mem. Pk.	
24A. DATE REC'D BY HEALTH DEPT.				24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS	
APR 5 1965				Robert E. Spitz, M.D.		George A. Kline 1348 N. Calhoun St	

VALLEY FORCE

DISPATCH

10/1/1918

10/1/1918

10/1/1918

10/1/1918

10/1/1918

10/1/1918

10/1/1918

10/1/1918

10/1/1918

10/1/1918

10/1/1918

65 3563

BALTIMORE CITY HEALTH DEPARTMENT

65 3563

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)T.  
CHARLES/JAHNIGEN

2. DATE AND HOUR PRONOUNCED DEAD

March 30, 1965

8:10 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4545 Reisterstown Road

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10 July 1883

9. AGE (in years  
last birthday)

82 81

If Under 1 Yr. If Under 24 Hrs.  
Months; Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Salesman

10B. KIND OF BUSINESS OR INDUSTRY

Carpeting

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Charles Theodore Jahnigen

14. MOTHER'S MAIDEN NAME

Marie Schreiber

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

215050956

17. INFORMANT

Margaret Jahnigen

ADDRESS

4545 Reisterstown Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Asphyxia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Aspiration of food stuff  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?  
Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Restaurant

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1707 N. Charles St.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 30 65 8:10 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Aspirated food in restaurant

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-31-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

3 Apr., 1965

23C. NAME of CEMETERY or CREMATORY

New Cathedral

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 5 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

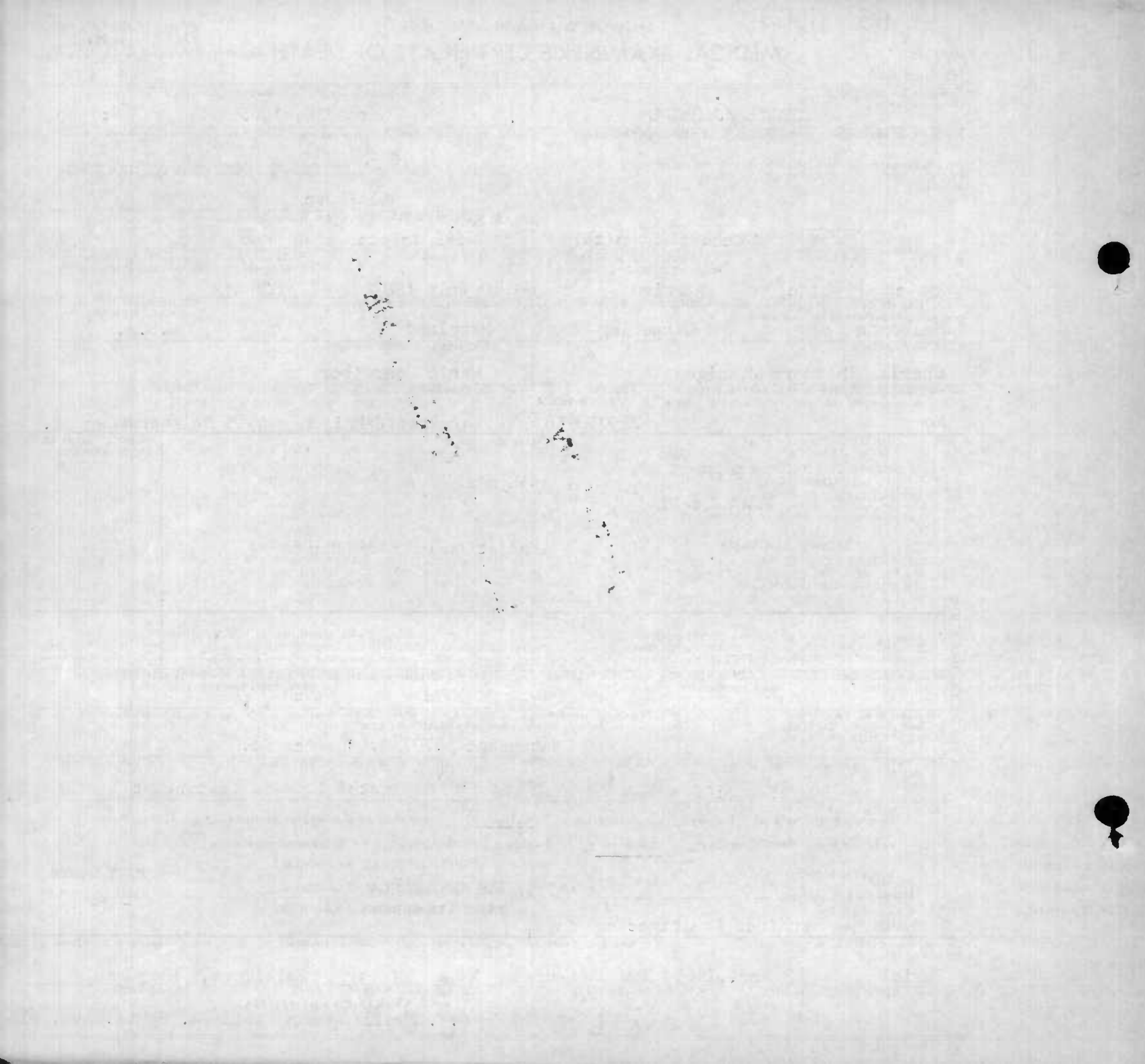
24C. FUNERAL DIRECTOR

J. E. Lowell Lemmon

ADDRESS

4611 Pk. Hghts. Ave. #15







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3564		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3564	
M.E. CASE NO.		CERTIFICATE OF DEATH		X	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Bicks, Jean Leonard		3/31/65		1:10 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
Montebello State Hospital		Maryland Anne Arundel			
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	
Male		White		Divorced	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. Under 1 Yr. Months Days	
6/12/1918		46			
11. BIRTH PLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Jean W. Bicks		Bruffler Leonard			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes Navy 263,588 WW		290-07-1110		Hospital Records	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
572.01 Regional Ileitis		2 yrs.			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
May, 1964		Resection of the Ilium		No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 3/30/65 19 to 3/31/65 19, that (I) (we) last saw the deceased alive on 3/31/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Daniel G. Lai		3/31/65			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Daniel G. Lai		2201 Argonne Drive, Baltimore, Md. 21218			
24A. BURIAL CREMATION REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4-2-65		Spring Hill Cem.	
24D. LOCATION (City, town, or county)		24E. STATE			
Easton		Md			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
APR 5 1965		Robert E. Barber		Robert E. Barber, Severna Park, Md.	

RECEIVED  
JAN 10 1964  
U.S. AIR FORCE  
HEADQUARTERS  
AIR FORCE  
WASHINGTON, D.C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

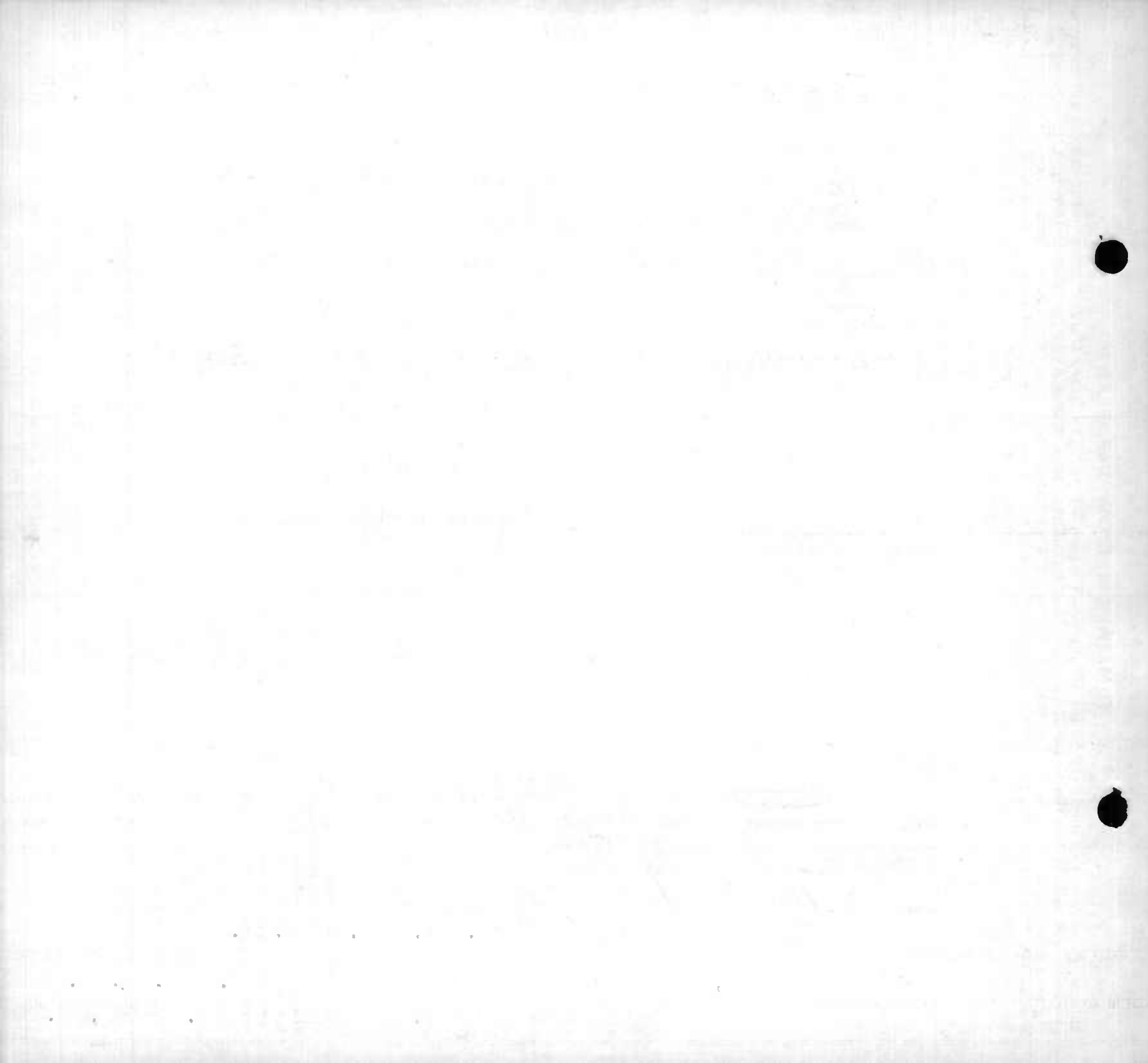
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="float: right;">65 3565</span>	
BIRTH NO. <span style="font-size: 1.5em;">65 3565</span>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">PAULINE K. RAZGAITUS</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 2, 1965 2:00 A.M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Union Memorial Hospital Baltimore, Maryland</span>			A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">Balto</span>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 53-00</span>		
			D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">1930 E. Joppa Rd</span>		
5. SEX <span style="font-size: 1.2em;">F</span>	6. RACE <span style="font-size: 1.2em;">CAUCASIAN</span>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Widowed</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6/29/96</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">68</span>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Lithuania</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">AMERICAN</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Kousha (UNKNOWN)</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">? UNKNOWN</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">NONE</span>	17. INFORMANT <span style="font-size: 1.2em;">Nosp. RECORDS</span>		ADDRESS
18. <span style="font-size: 1.2em;">422.1 I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">Cerebral Thrombosis</span> (B) <span style="font-size: 1.2em;">Congestive Heart Failure</span> (C) <span style="font-size: 1.2em;">Arteriosclerotic Cardiovascular Disease</span>		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4</span>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">○</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 28</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">April 2</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 2</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">David Merritt Mac Millan</span> M.D.				23B. DATE SIGNED <span style="font-size: 1.2em;">4/2/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">DAVID MERRITT MAC MILLAN</span> M.D.				23D. ADDRESS <span style="font-size: 1.2em;">UNION MEMORIAL HOSPITAL</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4-5-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Holy Redeemer Cem</span>	
				24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Balto MD</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 5 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">C. F. Evans</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">S. J. S. S. S.</span>	
				ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3566 4	
BIRTH NO. 65 3566		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>JOSEPH Williams PRICE, Jr</b>		2. DATE AND HOUR OF DEATH <b>MARCH 31, 1965 1:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2601</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>md. GEN Hosp.</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BAITIMORE 21206</b>			
		D. STREET ADDRESS (If rural, give location) <b>5704 RADECKE AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>N.B.</b>	8. DATE OF BIRTH <b>MARCH 30, 1965</b>	9. AGE (In years lost birthday)	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH Williams PRICE, SR</b>			14. MOTHER'S MAIDEN NAME <b>MARY KATHLEEN SMITH</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>MOTHER</b>	ADDRESS <b>SAME</b>	
18. <b>762.0 I</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Pulmonary atelectasis</b> DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>Hyaline membrane disease</b> DUE TO			
		(C)			
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>MARCH 30</b> 19 <b>65</b> to <b>MARCH 31</b> 19 <b>65</b> , that (II) <b>(we)</b> last saw the deceased alive on <b>MARCH 31</b> 19 <b>65</b> and that in <b>(my)</b> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> <b>(did not)</b> view the body after death.					
23A. SIGNATURE <b>Tai m Lav</b>				23B. DATE SIGNED <b>3-31-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>TAI M LAV</b>				23D. ADDRESS <b>Md. Gen. Hosp. Balto. Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 2, 1965</b>	24C. NAME of CEMETERY or CREMATORY <b>Sacred Heart of Jesus</b>	24D. LOCATION (City, town, or county) (State) <b>German Hill Rd. Bal. Co. Md. 21222</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Sale, M.D.</b>		25C. FUNERAL DIRECTOR <b>JOHN J. DUDA</b> ADDRESS <b>7922 Wise Ave. Dundalk, Md. 21222</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		BIRTH NO. <b>65 3567</b>		REGISTERED NO. <b>65 3567</b>	
M.E. CASE NO.				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ALLAN. D. AKERS</b>				2. DATE AND HOUR OF DEATH <b>4. 3. 65 12<sup>25</sup> P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home &amp; Hospital FAYETTE &amp; BROADWAY BALTIMORE</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE - DUNDALK</b> D. STREET ADDRESS (If rural, give location) <b>2708 W. WOODWELL RD.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>8. 29. 07.</b>	9. AGE (In years, lost birthday) <b>57 yrs.</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Addressograph Corp.</b>			11. BIRTHPLACE (State or foreign country) <b>TENN.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>CLARK AKERS</b>			14. MOTHER'S MAIDEN NAME <b>Julia Cecil</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>497-03-4687</b>		17. INFORMANT <b>N. Basu. Church Home &amp; Hosp.</b> ADDRESS
18. <b>163X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <b>Confident Bronchopneumonia of Left Lower Lobe</b> (B) <b>Empyema of Right Thorax</b> (C) <b>Metastasis of carcinoma of left lung to adrenal glands</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3. 24 1965</b> to <b>4. 3. 1965</b> , that (I) (we) last saw the deceased alive on <b>4. 3. 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>N. Basu</b>				23B. DATE SIGNED <b>4. 3. '65</b>	
23C. PHYSICIAN'S NAME (Type) <b>N. BASU</b>				23D. ADDRESS <b>church Home &amp; Hosp. Baltim.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 7, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial</b>	
24D. LOCATION <b>Washington Blvd. Dorsey, Md.</b>		24E. CITY, town, or county		24F. STATE	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>John E. Stachura</b>		25C. FUNERAL DIRECTOR <b>JOHN E. DUDA</b> ADDRESS <b>1722 Wise Ave. Dundalk, Md.</b>	





1  
H. 600

65 3568

BALTIMORE CITY HEALTH DEPARTMENT

65 3568

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Frank A. Herr

2. DATE AND HOUR PRONOUNCED DEAD

4/1/65

9:30 a.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2044 Walbrook Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

9/21/1908

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Truck Driver

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Joseph HERR

14. MOTHER'S MAIDEN NAME

MARY YATES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT ADDRESS (29)  
Mrs. Nancy S. Hannett

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Cirrhosis of Liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/2/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/3/1965

23C. NAME of CEMETERY or CREMATORY

New Cathedral Cem. BALTO.

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 5 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

G. TRUMAN Schwab

ADDRESS

3572 Frederick Ave. (29)

WALLER HONGE

PROBATION

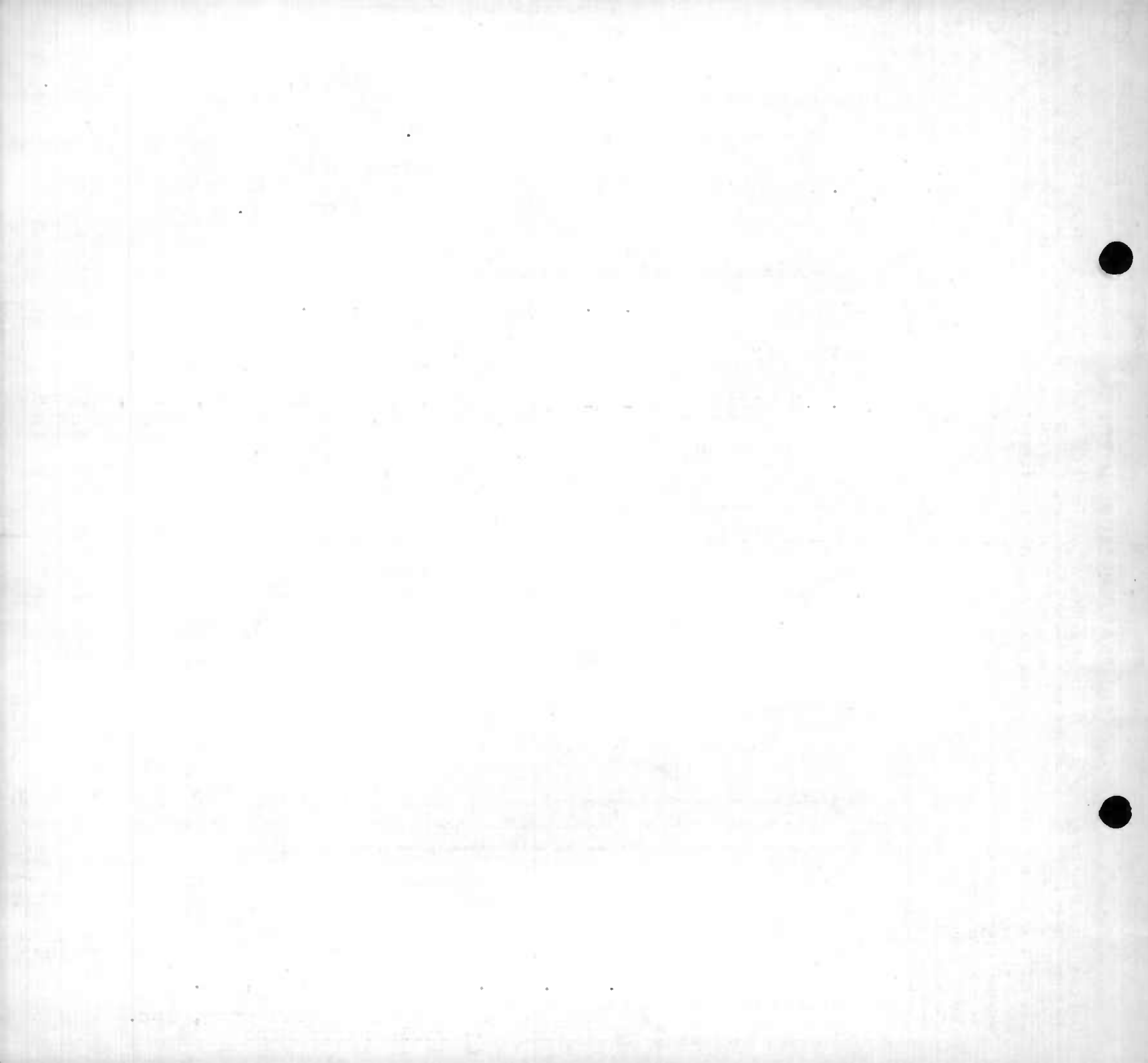
NOV 19 1964

2/1/65

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3569				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3569	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HOWARD ROBERT ORYE				2. DATE AND HOUR OF DEATH April 1, 1965 4:30 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 41 St. Joseph's Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. 8-01 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 3423 Elmora Ave.			
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 3/8/19	9. AGE (In years last birthday) 46	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10B. KIND OF BUSINESS OR INDUSTRY E & O R. R.		11. BIRTHPLACE (State or foreign country) Shenandoah, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Orye			14. MOTHER'S MAIDEN NAME Lillian Higgs				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W.2 Marine		16. SOCIAL SECURITY NO. 228-16-8318		17. INFORMANT ADDRESS Margaret McDonald Orye, wife, a bove			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Acute Myocardial Infarction</i> DUE TO (B) DUE TO (C)  INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>March 29 June 2</i> 19 <i>65</i> to <i>March 29</i> 19 <i>65</i> , and that (I) (we) last saw the deceased alive on <i>March 29</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) (did not) view the body after death.							
23A. SIGNATURE <i>Melvin F. Polek</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>April 2, 1965</i>	
23C. PHYSICIAN'S NAME (Type) MELVIN F. POLEK				23D. ADDRESS M.D. 3603 Belair Rd. Balt. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/65		24C. NAME OF CEMETERY or CREMATORY Balto. Nat. Cem.		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR ADDRESS Schimunek Funeral Home, Inc. 3337 Enoch Lane			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3570	
BIRTH NO. 65 3570		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) KOHLER, WALTER ALBERT (also known as GRABOWSKI)		2. DATE AND HOUR OF DEATH 4/1/65 4:30 P. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD. BALTIMORE, MARYLAND 21218				A. STATE MARYLAND B. COUNTY 26-10	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location) 444 NORTH BOULDER ST	
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 7/1/98	9. AGE (In years last birthday) 66	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICEMAN		10B. KIND OF BUSINESS OR INDUSTRY CITY OF BALTIMORE		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME WALTER GRABOWSKI		14. MOTHER'S MAIDEN NAME LILLIAN MALECKA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES 6/14/17 TO 6/2/19		16. SOCIAL SECURITY NO. 215 46 6811		17. INFORMANT ADDRESS V.A. HOSPITAL, BALTIMORE, MD. 21218	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
(A) Aspiration Pneumonia				2 days	
(B) Tracheo-Esophageal Fistula				3 months	
(C) Carcinoma of The Esophagus				5 months	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION March 31 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Tracheo-Esophageal Fistula		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from DECEMBER 29 1964 to APRIL 1 1965, that (X) (we) lost the deceased on APRIL 1 1965 and that in (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.					
23A. SIGNATURE Howard H. Gendason M.D.				23B. DATE SIGNED April 2, 1965	
23C. PHYSICIAN'S NAME (Type) H. OWARD H. GENDASON				23D. ADDRESS V.A. HOSPITAL 3900 LOCH RAVEN BLVD BALTIMORE, MD. 21218	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/5/65		24C. NAME OF CEMETERY or CREMATORY Holy Rosary Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR Robert E. Schimunek		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Breckins Lane	

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# FUNERAL DIRECTOR: IMPORTANT

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Baltimore City Health Department				Baltimore City Health Department	
BIRTH NO. 65 3571				CERTIFICATE OF DEATH	
M.E. CASE NO. 65 3571				Registered No. 65 3571	
1. NAME OF DECEASED (Type or Print) <b>LATIMER, GEORGE FRANKLIN</b>			2. DATE AND HOUR OF DEATH <b>April 2, 1965 11:10 A M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>V-35</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Marietta</b>		
			D. STREET ADDRESS (If rural, give location) <b>E. Hazel Avenue</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>3/25/10</b>	9. AGE (In years last birthday) <b>55</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>	11. BIRTHPLACE (State or foreign country) <b>Blairsville, Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Charles F Latimer</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Roan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 3/25/43 - 12/19/44</b>		16. SOCIAL SECURITY NO. <b>159-12-5025</b>	17. INFORMANT <b>VA Hospital Records Baltimore, Maryland 21218</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>(A) Respiratory failure</b> DUE TO <b>(B) Chronic Lung disease</b> DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(C) Tuberculosis, Pulmonary, Activity questionable</b>			INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>No</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (✓) (this hospital) attended the deceased from <b>March 10 th 19 65</b> to <b>April 2nd 19 65</b> , that (✓) (we) last saw the deceased alive on <b>April 2nd 19 65</b> and that in (✓) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (✓) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert N. DiSimone</b> M.D.				23B. DATE SIGNED <b>4/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT DiSIMONE</b>				23D. ADDRESS <b>VA Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Removal</b>		24B. DATE <b>Apr. 3, 1965</b>		24C. NAME OF CEMETERY or CREMATORY <b>Silver Springs Cemetery</b>	
24D. LOCATION <b>Silver Springs, Penna.</b>		24E. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>			
25A. NAME OF REGISTRAR <b>William Cook, Inc.</b>		25B. FUNERAL DIRECTOR ADDRESS <b>1217 St. Paul St.</b>			

Robert M. Johnson



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3572		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3572	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>(STEVEN) STEFAN MATUSZAK</b>			2. DATE AND HOUR OF DEATH <b>4-3-65 1:15 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Maryland General Hospital</b>			A. STATE <b>Maryland</b> B. COUNTY <b>26-05</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>3125 Folcroft St.</b>		
5. SEX <b>Male</b>	6. RACE <b>Can</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>12-8-85</b>	9. AGE (In years lost birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>UNKNOWN</b>			14. MOTHER'S MAIDEN NAME <b>Rosa Arenty</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs. Frieda F. Matuzak</b>		ADDRESS <b>3125 Folcroft St.</b>
18. <b>527.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial infarction</b>			CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO <b>pulm. emphysema</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>March 16 1965</b> to <b>April 3 1965</b> , that (I) (we) last saw the deceased alive on <b>April 3 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>L.S. Jell</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 3, 1965</b>
23C. PHYSICIAN'S NAME (Type) <b>L. G. T. 1127</b>			23D. ADDRESS <b>Maryland General Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4-2-65</b>	24C. NAME OF CEMETERY or CREMATORY <b>OAK HAWN Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>BALTO., MD.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Seibert</b>	25C. FUNERAL DIRECTOR <b>Wentley Miller</b>		ADDRESS <b>2334 Jefferson St.</b>

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 3573</u>	
BIRTH NO. <u>65 3573</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>TWIST Mr. HENRY B.</u>		2. DATE AND HOUR OF DEATH <u>APRIL 2, 1965</u> <u>1:35 P.M.</u>	
3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>7-01</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>CHURCH HOME AND HOSPITAL</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>3033 McELDERRY STREET.</u>			
5. SEX <u>M.</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-23-96</u>	9. AGE (In years lost birthday) <u>68</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND.</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>STEPHEN TWIST.</u>			14. MOTHER'S MAIDEN NAME <u>THERESA CAPIE</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-03-1553</u>		17. INFORMANT ADDRESS <u>Mrs. Dora Twist - 3033 Mc Elderry St.</u>	
18. <u>199.214760X</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <u>Disseminated Carcinoma</u> DUE TO <u>origin unknown.</u> (B) <u>Hypertensive Cardiovascular disease</u> DUE TO <u>3-4 years</u> (C) <u>Diabetes Mellitus</u> <u>6-7 years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
19A. DATE OF OPERATION <u>0</u> <u>NO</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3/26/65</u> 19 to <u>4/2/65</u> 19, that (I) (we) last saw the deceased alive on <u>4/2/65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Antoine Arrage</u> M.D.				23B. DATE SIGNED <u>4/2/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>ANTOINE ARRAGE</u> M.D.				23D. ADDRESS <u>Church Home &amp; Hosp</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>4-5-65</u>	24C. NAME OF CEMETERY or CREMATORY <u>HOLY REDEEMER CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1965</u>		25B. NAME OF REGISTRAR <u>Robert S. Johnson</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Jefferson St.</u>	

STATE OF NEW YORK

IN SENATE  
JANUARY 12, 1904

REPORT  
OF THE  
COMMISSIONER OF THE LAND OFFICE

ALBANY:  
J. B. LEECH, JR.,  
PRINTERS, 1904.

1904

State of New York

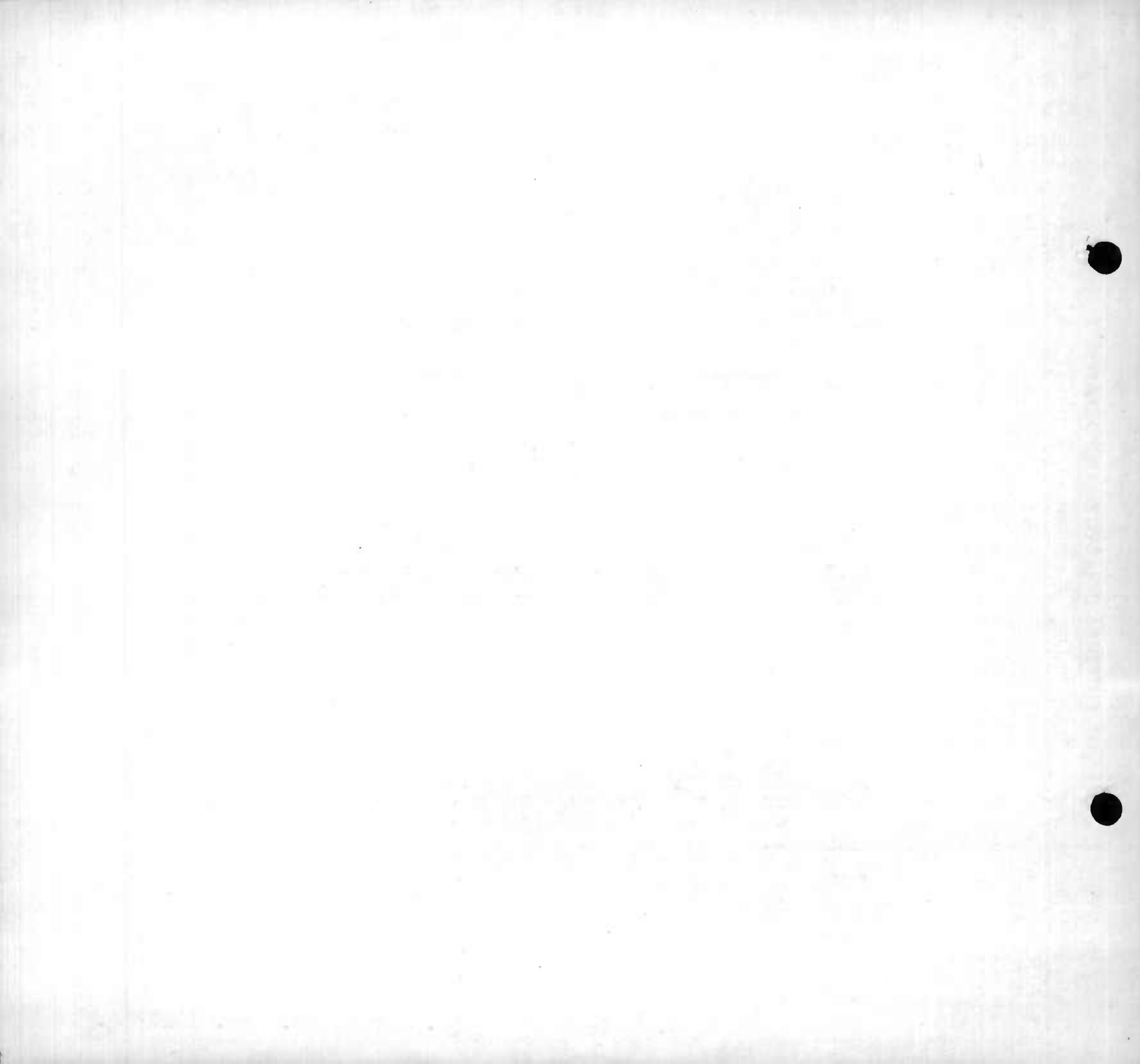
Commissioner of the Land Office

ALBANY, N. Y.

# FUNERAL DIRECTOR: IMPORTANT

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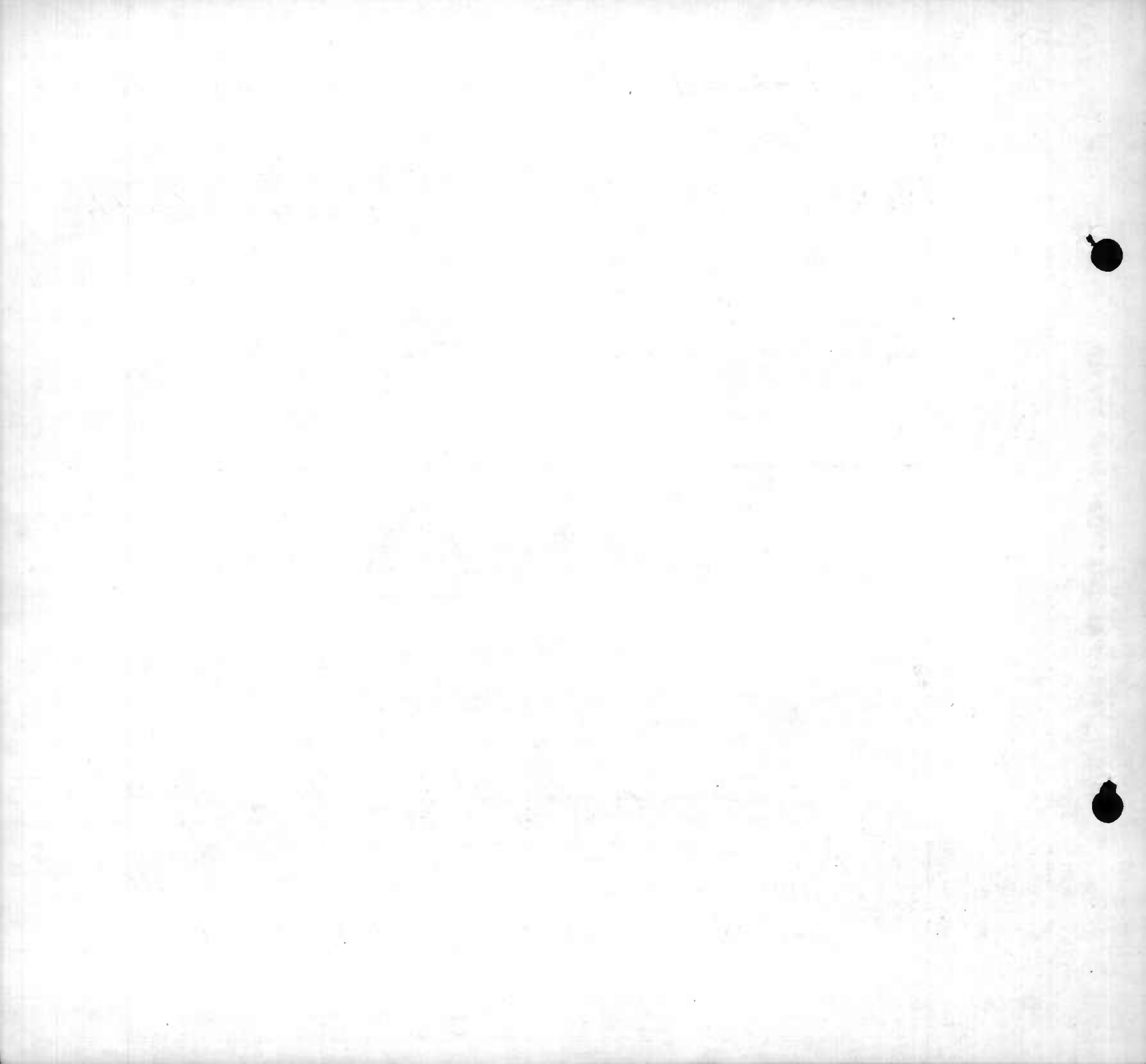
BIRTH NO. 65 3574		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3574	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Michael Morris</i>		2. DATE AND HOUR OF DEATH <i>3-31-65- 5:55 PM</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Men Hospital</i>		A. STATE <i>MD</i>		B. COUNTY <i>Harbor</i>	
(If not in hospital or institution, give street address or location) <i>D.O.A.</i>		C. CITY OR TOWN <i>Balt</i>		(If outside city limits, write RURAL and give township) <i>17th 14-01</i>	
D. STREET ADDRESS <i>1701 E. Euter Place</i>		E. CITY OR TOWN		F. STATE	
5. SEX <i>M</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>married</i>	8. DATE OF BIRTH <i>Dec 10 1881</i>	9. AGE (In years lost birthday) <i>83</i>	10. If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. <i>420.11</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) <i>Acute Coronary Thrombosis - 4th mo</i> DUE TO (B) <i>Chronic Coronary</i> DUE TO <i>1944 - Acute Myocardial Infarction</i> (C) <i>1962 - 2nd Acute Coronary</i> <i>1963 - 3rd Acute Coronary</i> <i>1964 - (Nov 8 - to Dec 6) - 4th Acute Coronary</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1943 to 4th Corvay</i> 19 <i>March 31</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>March 25</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Dr. Bernard J. Cohen</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>3-31-65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Dr. Bernard J. Cohen</i>		23D. ADDRESS <i>UNIVERSITY MEDICAL SCHOOL</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>4/1/65</i>		24B. DATE		24C. NAME OF CEMETERY & CREMATORY	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR <i>Robert E. Stahler</i>		24F. FUNERAL DIRECTOR <i>Wm. E. Cook &amp; Co. Inc.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 5 1965</i>		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
25D. ADDRESS		25E. NAME OF REGISTRAR		25F. FUNERAL DIRECTOR	



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BIRTH NO. 65 3575		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3575	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) <b>HAROLD W. Stewart</b>	
2. DATE AND HOUR OF DEATH <b>4-2-65 11:10 A.M.</b>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md.</b> B. COUNTY <b>Balto.</b>	
5. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mercy Hospital</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Lutherville 5300</b>	
6. SEX <b>M</b>		7. RACE <b>W</b>		D. STREET ADDRESS (If rural, give location) <b>1 Atherton Garth</b>	
8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W</b>		9. DATE OF BIRTH <b>2-5-10</b>		10. AGE (In years last birthday) <b>55</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (State or foreign country) <b>Cambridge Maryland</b>	
14. FATHER'S NAME <b>Sylvester Stewart</b>		15. MOTHER'S MAIDEN NAME <b>Tina Dayton</b>		16. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
17. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO.		19. INFORMANT <b>1 Atherton Garth Lutherville</b> <b>Miss Virginia L. Stewart</b>	
20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>381.01</b>		21. CAUSE OF DEATH (A) DUE TO <b>Septic coma</b> (B) DUE TO <b>Septic failure</b> (C) <b>Posthectic cirrhosis</b>		22. INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>2 years</b> <b>2 years</b>	
23. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
25. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>2/14</b> 19 <b>65</b> to <b>April 2</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 2</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE <b>Nelson C. Sun</b>		23B. DATE SIGNED <b>4/2/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>NELSON C. SUN</b>		23D. ADDRESS <b>MERCY HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/5/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>CLUB S. Baltimore</b>	
25C. FUNERAL DIRECTOR <b>Henry Gander &amp; Sons Inc.</b>		25D. ADDRESS <b>Baltimore, Maryland 21213</b>			





2.520

65 3576

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 3576

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH J. LOUNGE

2. DATE AND HOUR PRONOUNCED DEAD

March 31, 1965

10:40 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Maryland General Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1011 N. Montford Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

Sept. 22, 1904

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Plumber

10B. KIND OF BUSINESS OR INDUSTRY

Plumbing

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Joseph B. Lounge

14. MOTHER'S MAIDEN NAME

Annie B. Freshlein

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

9/16/42 5/4/43

16. SOCIAL  
SECURITY NO.

212 14 8612

17. INFORMANT

ADDRESS

Mr. Henry A. Lounge 1816 N. Dallas ST

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty metamorphosis of liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Arteriosclerotic cardiovascular disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-31-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/5/65

23C. NAME of CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

(State)

Baltimore Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 5 1965

Robert E. Taylor, M.D.

Henry Sander &amp; Sons Inc.

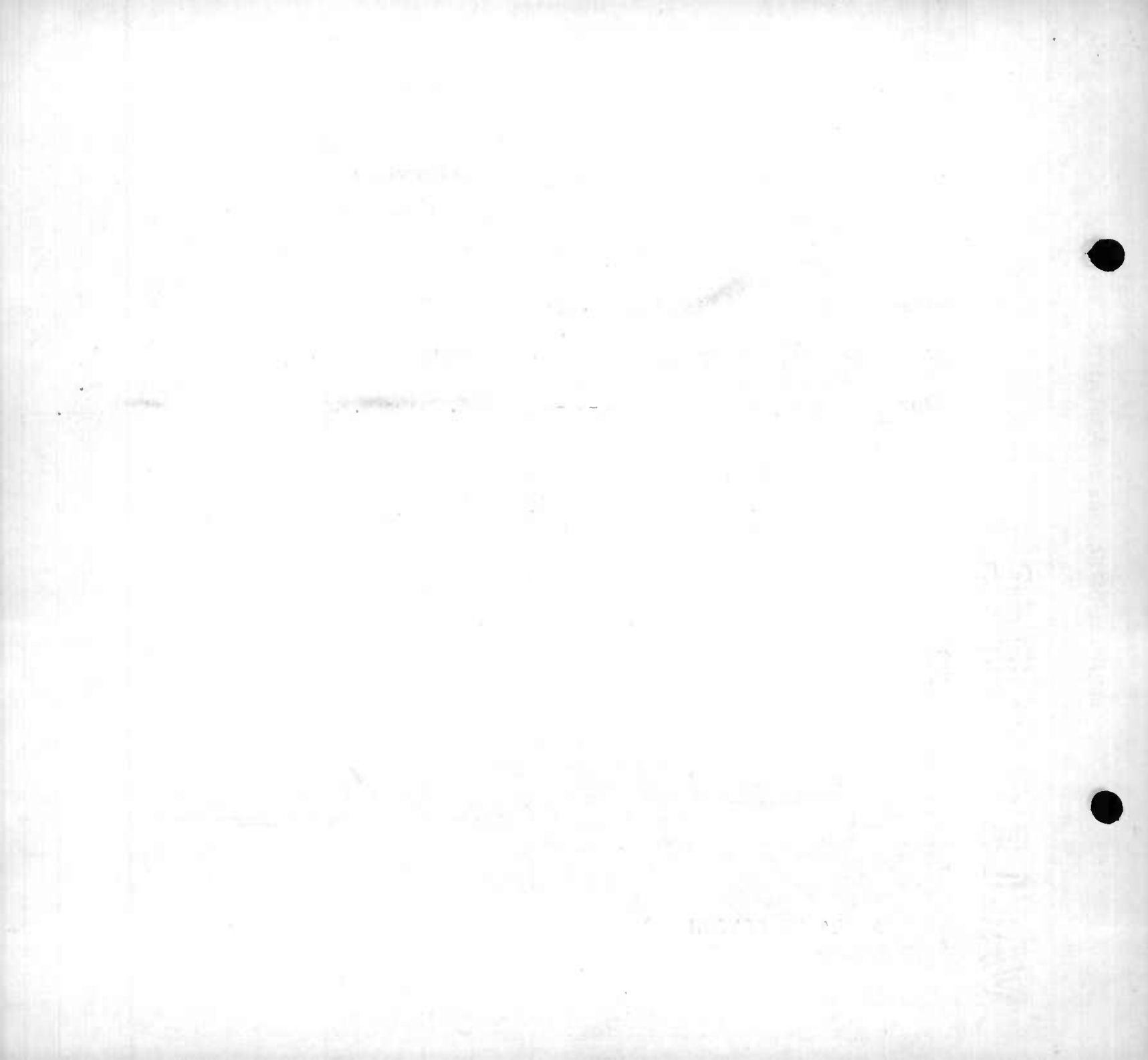
Baltimore, Maryland

VALLEY & HOBBS

# FUNERAL DIRECTOR: IMPORTANT

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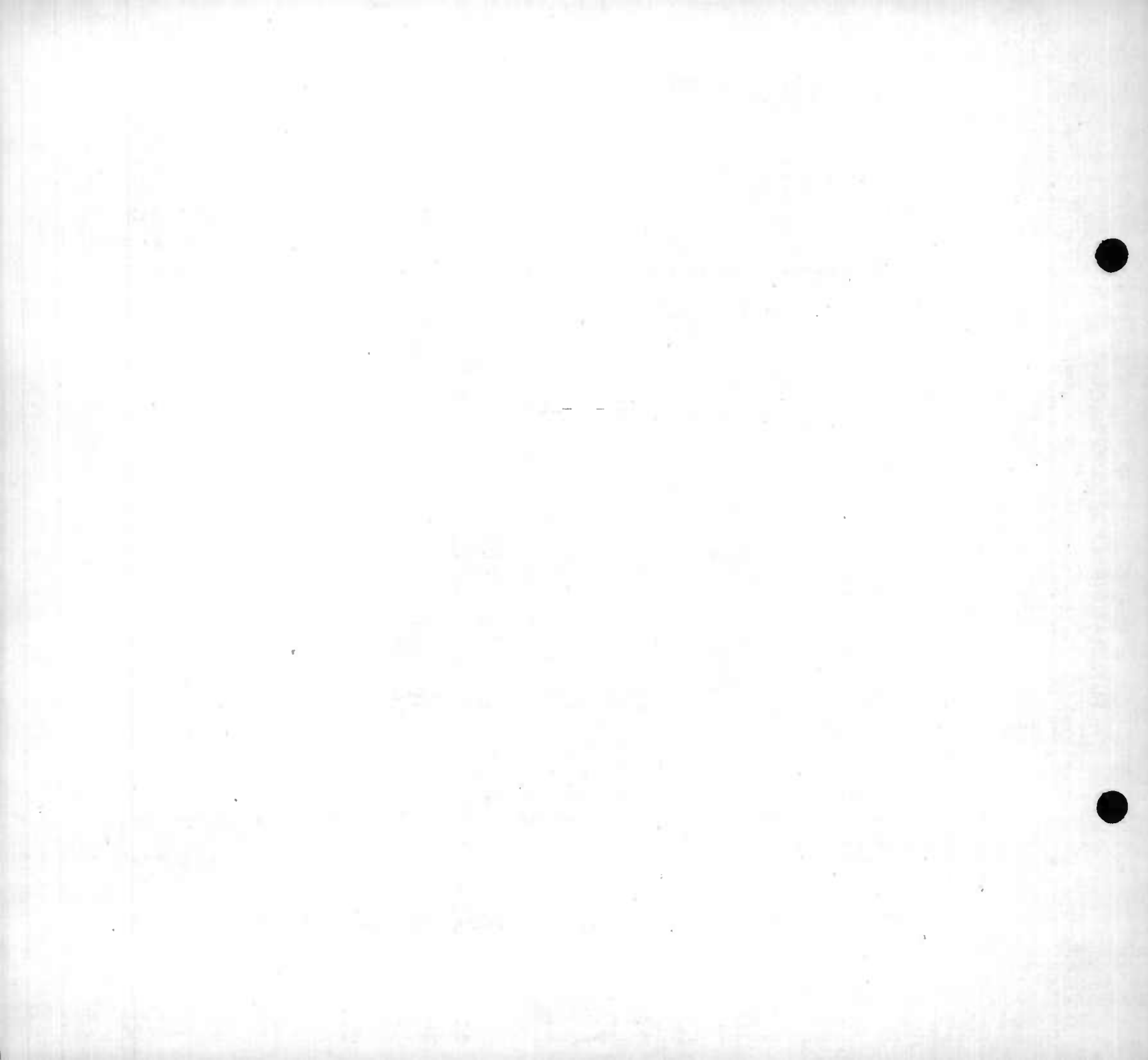
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 3577		REGISTERED NO. 65 3577	
<b>CERTIFICATE OF DEATH</b>							
1. NAME OF DECEASED (Type or Print) <b>LITTLETON, OLIVER WILBERT JR.</b>				2. DATE AND HOUR OF DEATH <b>4/2/65 11 50 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>14</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>Balto</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Catonsville</b>			
				D. STREET ADDRESS (If rural, give location) <b>108 HILTON AVE 28</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10/25/96</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Attorney</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Fidelity Deposit</b>		11. BIRTHPLACE (State or foreign country) <b>BALT, MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>WILLIAM T. LITTLETON</b>				14. MOTHER'S MAIDEN NAME <b>MARY KATE HACKETT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>215-10-1634</b>		17. INFORMANT ADDRESS <b>Mrs. Alice M. Littleton Catonsville, Md.</b>			
<b>330X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid hemorrhage</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Severe arteriosclerosis, generalized</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			
				INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/31/1965</b> to <b>4/2/1965</b> , that (I) (we) last saw the deceased alive on <b>4/2/1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. Laird Bryson M.D.</b>				23B. DATE SIGNED <b>4/2/65</b>		23C. PHYSICIAN'S NAME (Type) <b>A. LAIRD BRYSON</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Baltimore National Cent.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>W. J. Fickner</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Balto, Md. 17</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="font-size: 24pt;">65 3578</span>		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. <span style="font-size: 24pt;">65 3578</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 18pt;">Willie May Landon</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 18pt;">April 2, 1965</span> <span style="float: right;">2 45 M.</span>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 18pt;">6000 Bellona Avenue Edgewood Nursing Home</span>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 18pt;">Maryland</span> B. COUNTY <span style="font-size: 18pt;">Baltimore</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 18pt;">Baltimore</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 18pt;">221 Rogers Forge Road 21212</span>		
5. SEX <span style="font-size: 18pt;">Female</span>	6. RACE <span style="font-size: 18pt;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 18pt;">Single</span>	8. DATE OF BIRTH <span style="font-size: 18pt;">3/15/1883</span>	9. AGE (In years last birthday) <span style="font-size: 18pt;">82</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 18pt;">Retired Stenographer</span>			11. BIRTHPLACE (State or foreign country) <span style="font-size: 18pt;">Maryland</span>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <span style="font-size: 18pt;">William Landon</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 18pt;">Annie E. Fontaine</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 18pt;">No None</span>			16. SOCIAL SECURITY NO. <span style="font-size: 18pt;">220-46-1175</span>	17. INFORMANT ADDRESS <span style="font-size: 18pt;">3900 Roland Avenue Miss Edna Little Baltimore, Md. 21211</span>	
18. <span style="font-size: 24pt;">260X I</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <span style="font-size: 24pt;">II</span> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			CAUSE OF DEATH <span style="font-size: 24pt;">(A) Hypertensive Basis</span> DUE TO <span style="font-size: 24pt;">Diabetes Mellitus</span>  <span style="font-size: 24pt;">(B) Generalized Arteriosclerosis</span> DUE TO  <span style="font-size: 24pt;">(C) Senility</span>		
19A. DATE OF OPERATION <span style="font-size: 24pt;">None</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 18pt;">June 1962</span> to <span style="font-size: 18pt;">April 2nd 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 18pt;">April 2nd 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 24pt;">[Signature]</span>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 18pt;">4/3/65</span>
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 18pt;">M Paul Byerly</span>			23D. ADDRESS M.D. <span style="font-size: 18pt;">5520 York Rd Balto 21212 Md</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 18pt;">Burial</span>		24B. DATE <span style="font-size: 18pt;">4/5/1965</span>	24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 18pt;">Loudon Park Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 18pt;">Baltimore, Maryland</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 18pt;">APR 5 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 18pt;">Robert E. [Signature]</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 18pt;">5724 [Signature] Balto., Md. 21217</span>	



D-530

65 3579

BALTIMORE CITY HEALTH DEPARTMENT

65 3579

BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
JOHN W. DANDY			4/2/65 1 3:40 a. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
			A. STATE Maryland B. COUNTY		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
33 Johns Hopkins Hospital			Baltimore 2602		
D. STREET ADDRESS (If rural, give location)			5305 Moravia RD. 6		
Parkside Gardens Apartments Baltimore, Md.					
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.
male	white	Single	June 1, 1934	30	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Tilsetter		Tile Contractor		Baltimore, Maryland	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Elmer W. Dandy			Beulah M. McDonald		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			216-30-9344		
17. INFORMANT			ADDRESS		
Mr. E. J. Bayliss			413 Gralan Road Catonsville, Md. 28		
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Gunshot wound of abdomen		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(B) DUE TO		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(C) DUE TO		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
					no
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
			street		4827 Trusdale Ave.
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?
4 2 65 1:15 a.m.			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		shot self in stomach
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
W.U. Pitz, M.D.			ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)			23B. DATE		23C. NAME OF CEMETERY or CREMATORY
Burial			4/5/65		Baltimore National Cemetery
24A. DATE REC'D BY HEALTH DEPT.			24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR
APR 5 1965			Robert E. [unclear]		Wm. F. Fickens & Sons
					Balto., Md. 21217





*Handwritten signature or text, possibly "J. H. Smith" or similar, in cursive script.*



B-631

65 3580

BALTIMORE CITY HEALTH DEPARTMENT

65 3580

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

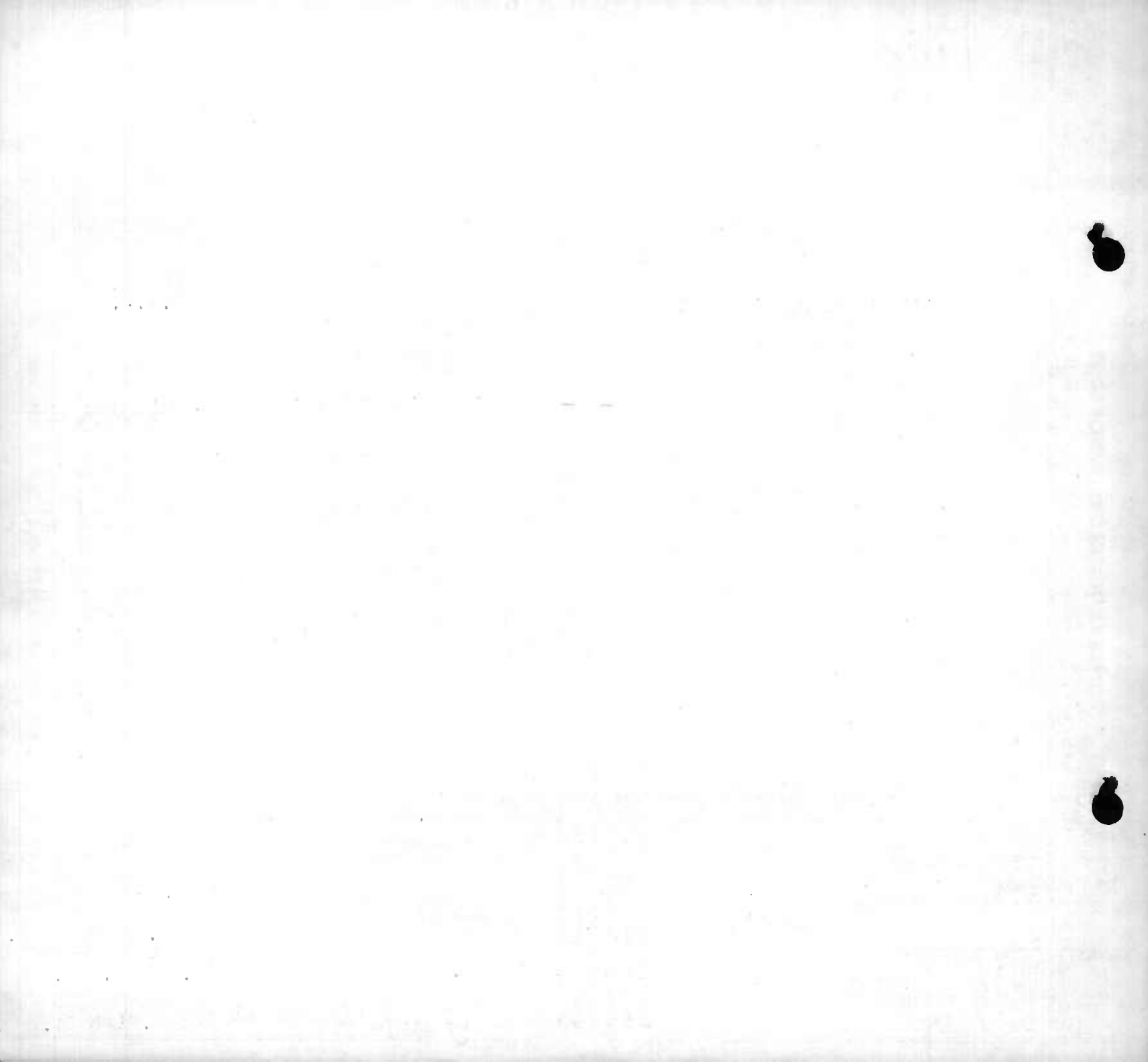
1. NAME OF DECEASED (Type or Print) <b>FREDERICK M. BRADFORD</b>		2. DATE AND HOUR PRONOUNCED DEAD <b>April 3, 1965</b> <b>6:50 a</b> <b>M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>37 Mercy Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>C. CITY OR TOWN</b> (If outside corporate limits, write RURAL and give township) <b>Baltimore</b> <b>D. STREET ADDRESS</b> (If rural, give location) <b>109 W. Saratoga St. 21201</b>	
5. SEX <b>male</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH <b>May 3, 1929</b>
9. AGE <b>35</b> years (last birth)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Interior Decorator</b>	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Frederick Blatt</b>		14. MOTHER'S MAIDEN NAME <b>Lois Mowry</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mr. Robert Mowry</b>		ADDRESS <b>1244 Stone Street Chicago, Ill.</b>	
18. CAUSE OF DEATH <b>E977.8</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Combination action of alcohol and barbiturates</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>4 3 65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
21C. WHERE DID INJURY OCCUR? <b>109 W. Saratoga St.</b>		21D. TIME OF INJURY (APPROX.) <b>4 3 65 a m.</b>	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Took combination of alcohol and barbiturates</b>	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breitenecker</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		23B. DATE <b>4/6/1965</b>	
23C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Crematory</b>		23D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		24B. NAME OF REGISTRAR <b>Robert E. [Signature]</b>	
24C. FUNERAL DIRECTOR <b>W.B. Fisher &amp; Sons</b>		ADDRESS <b>Balto. Md. 21217 north &amp; Pa. Ave.</b>	

VALLEY FORTGE

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

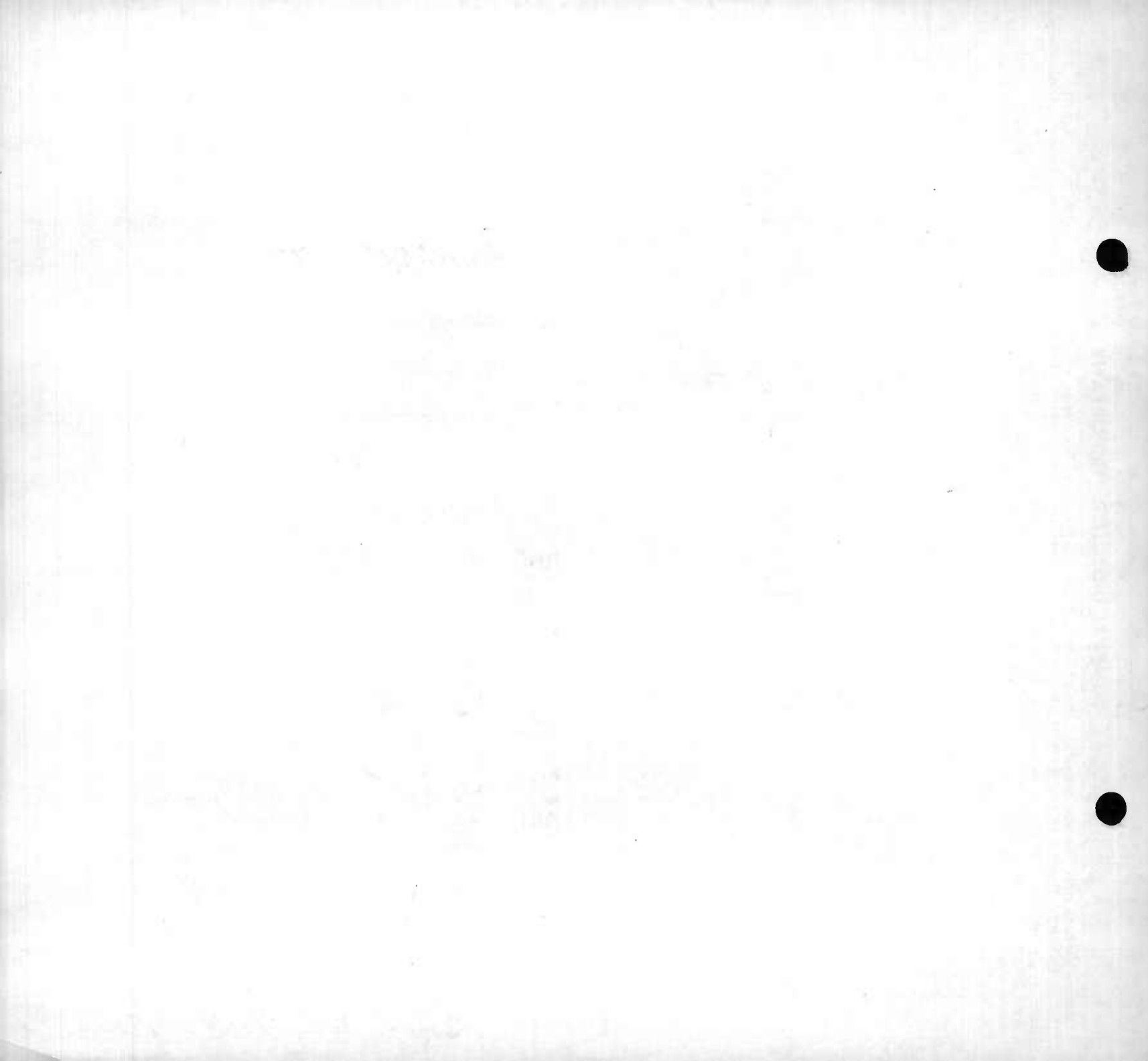
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 3581					CERTIFICATE OF DEATH					Registered No. 65 3581				
1. NAME OF DECEASED (Type or Print) <i>Vincent Cutellucci</i>										2. DATE AND HOUR OF DEATH <i>4-2-65 1-30A M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY <i>6000 MANNINGTON AVE BALTO.</i>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4 Bon Secour Hospital</i>										C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>BALTO. MD. 5300</i>				
D. STREET ADDRESS (If rural, give location)														
5. SEX <i>M</i>		6. RACE <i>W</i>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>6/11/91</i>		9. AGE (In years last birthday) <i>73</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor Retired</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Tailor Shop</i>					11. BIRTHPLACE (State or foreign country) <i>Italy</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>RALPH CUTELLUCCI</i>					14. MOTHER'S MAIDEN NAME <i>QUARTAPELLA ANNA</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>					16. SOCIAL SECURITY NO. <i>216-03-0708</i>					17. INFORMANT ADDRESS <i>Elsie Cutellucci 6000 Mannington Ave</i>				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>420.041 260X</i>										CAUSE OF DEATH (A) <i>Cardiac arrest</i> DUE TO (B) <i>Chronic atherosclerotic heart disease</i> DUE TO (C) <i>Years</i>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Diabetes Mellitus</i>														
19A. DATE OF OPERATION <i>0</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>4-1-65</i> to <i>4-2-65</i> , that (I) (we) lost saw the deceased alive on <i>4-2-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>Octavio A Ruiz</i> M.D.										23B. DATE SIGNED <i>4-2-65</i>				
23C. PHYSICIAN'S NAME (Type) <i>Octavio A Ruiz</i> M.D.										23D. ADDRESS <i>Bon Secour Hospital 2025 W. Fayette St.</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>1965 April 5</i>					24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer Cem.</i>				
24D. LOCATION (City, town, or county) (State) <i>4430 Belair Rd. Balt. Md.</i>					25A. DATE REC'D BY HEALTH DEPT. <i>APR 5 1965</i>					25B. NAME OF REGISTRAR <i>Francis Della Voce</i>				
25C. FUNERAL DIRECTOR ADDRESS <i>322 S. High St.</i>														



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 3582</u>	
BIRTH NO. <u>65 3582</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Jesse A. Burton</u>		2. DATE AND HOUR OF DEATH <u>4-3-65</u> <u>1 6 10</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>14-62</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>George Washington CARVER Nursing Home</u>		D. STREET ADDRESS (If rural, give location) <u>525 McMechen Street</u>			
5. SEX <u>Male</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>March 3, 1888</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>Walter Burton</u>		14. MOTHER'S MAIDEN NAME <u>Edvina Jones</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-28-5029</u>		17. INFORMANT <u>Charl #634</u>	
18. <u>450.11</u>		CAUSE OF DEATH		ADDRESS <u>607 Penna Ave</u>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <u>Broncho Pneumonia</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Gen. Arteriosclerosis</u> DUE TO		<u>Unknown</u>	
		(C) <u>Congestive of Rt. Foot</u>		<u>2 months</u>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/10</u> 19 <u>65</u> to <u>April 3</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>April 2</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>E.E. Holt</u>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4/5/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>E.E. Holt</u>		23D. ADDRESS M.D. <u>3715 Liberty Bldg. Ave. Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-6-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt Auburn Cem</u>	
24D. LOCATION <u>Baltimore, Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Jenkins</u>	
25C. FUNERAL DIRECTOR <u>George S. Baker</u>		25D. ADDRESS <u>1348 N. Calhoun St</u>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3583				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3583	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>LUCEY, ANNA BARBARA</b>				2. DATE AND HOUR OF DEATH <b>4/3/65 3:30 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>14</b> FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>27-34</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO</b> D. STREET ADDRESS (If rural, give location) <b>4012 CENTURY ROAD</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>W</b>	8. DATE OF BIRTH <b>7/4/94</b>	9. AGE (In years lost birthday) <b>70</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HSWF</b>	11. BIRTHPLACE (State or foreign country) <b>MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>MD</b>
13. FATHER'S NAME <b>? JOHN SCHOAL</b>				14. MOTHER'S MAIDEN NAME <b>? MARY GROETTE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-23-328</b>		17. INFORMANT <b>Family</b> ADDRESS <b>4012 CENTURY ROAD CITY</b>	
18. <b>203X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <b>Multiple myeloma</b> (B) <b>Brucella pneumonia</b> (C) <b>Coronary heart disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/18/1965</b> to <b>4/3/1965</b> , that (I) (we) last saw the deceased alive on <b>4/3/1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>A. Laird Bryson MD</b>				23B. DATE SIGNED <b>4/3/65</b>		23C. PHYSICIAN'S NAME (Type) <b>A. LAIRD BRYSON</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>				23E. FUNERAL DIRECTOR <b>Walter C. Calkin</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-6-65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>A. C. E. Taylor</b>		25C. ADDRESS <b>5444 Belair Rd</b>			

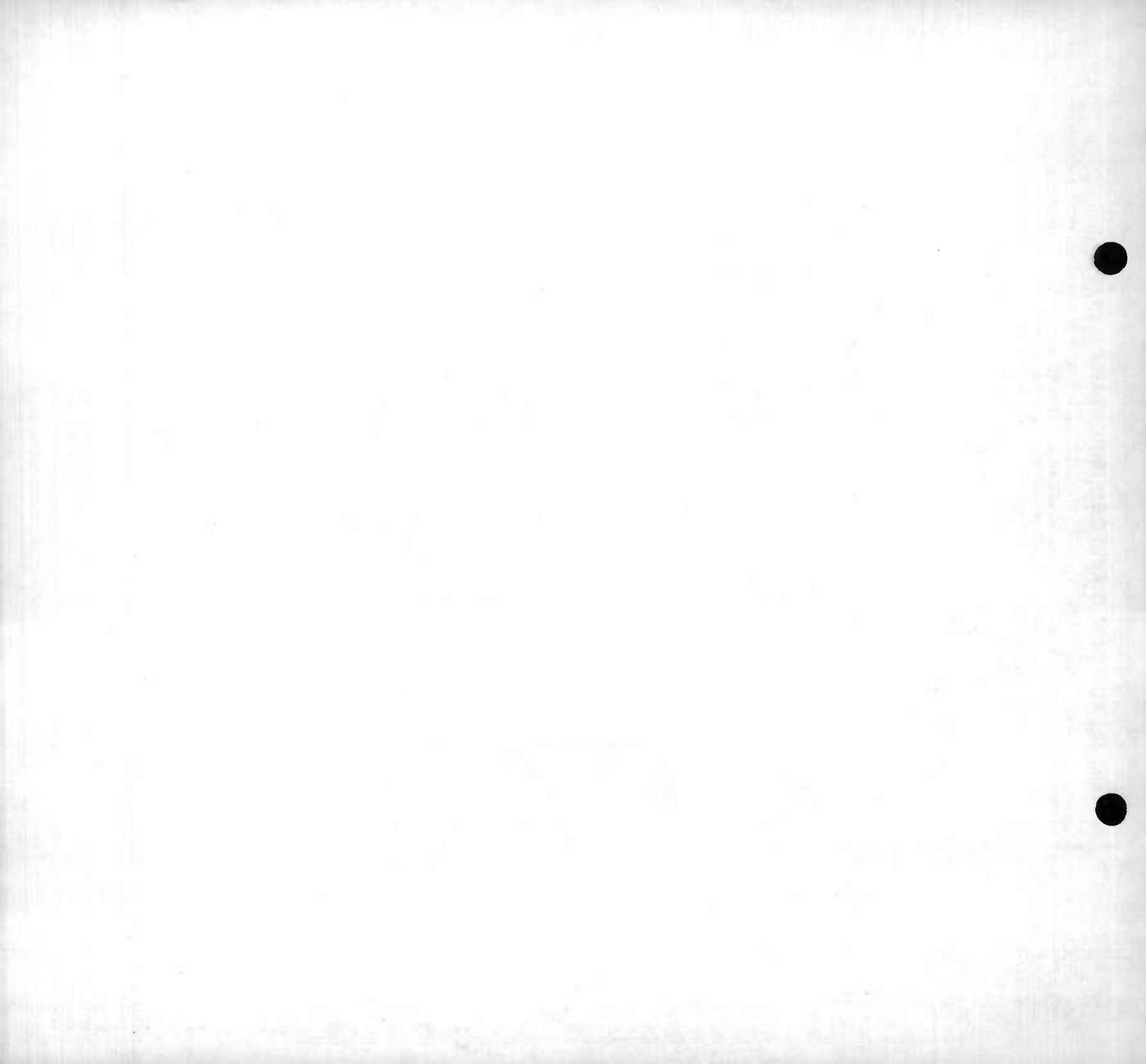




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

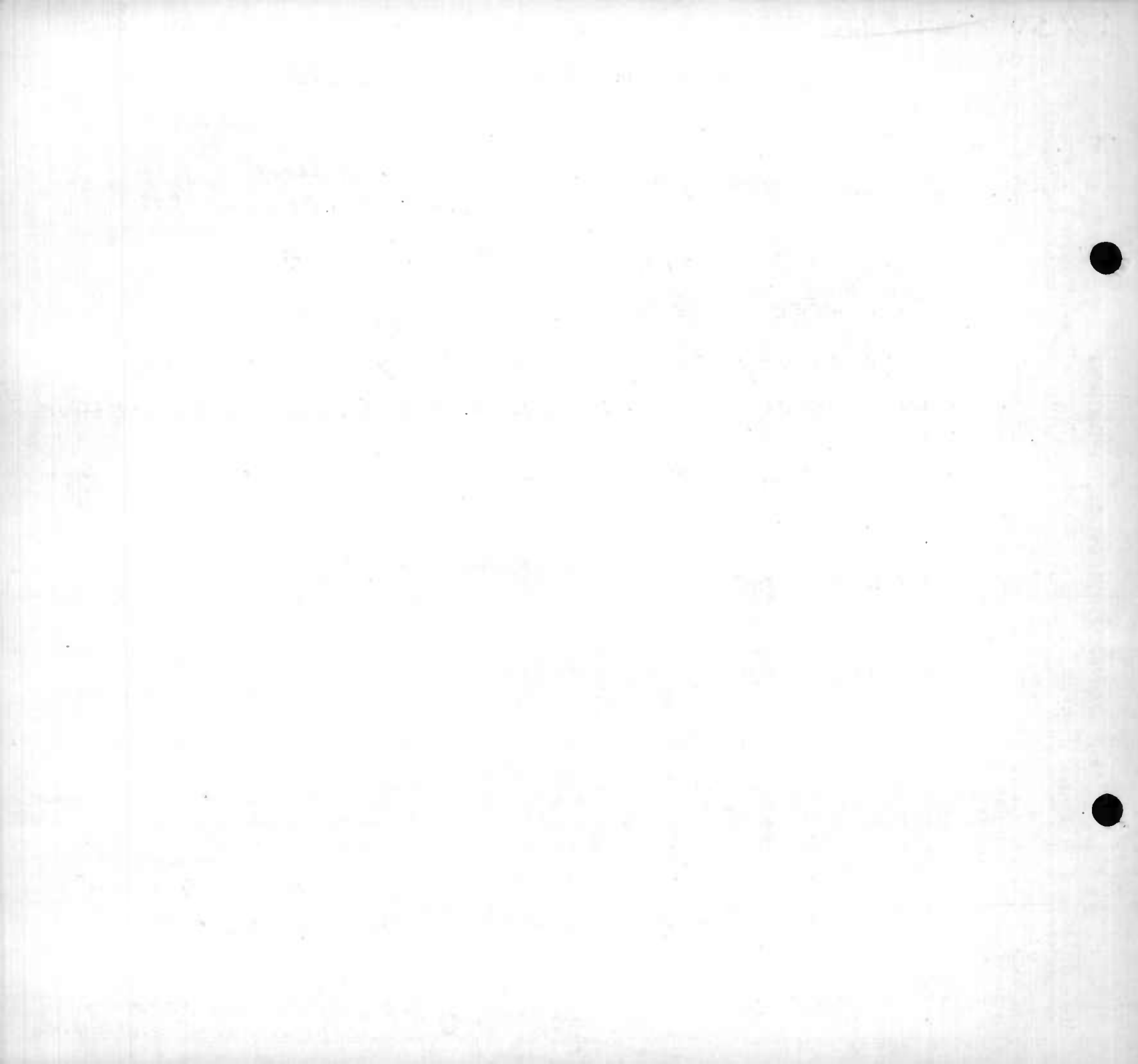
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 3584</b>		<b>CERTIFICATE OF DEATH</b>		65 3584	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Lillian Bertha DeCrescent</b>		2. DATE AND HOUR OF DEATH <b>4/3/65 5.30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>47</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2634</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Hospital for the Women of Maryland</b>		D. STREET ADDRESS (If rural, give location) <b>4926 Greencrest Rd. 2</b>		<b>8219 Belair Rd.</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>5-10-05</b>	9. AGE (In years last birthday) <b>59</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Walter (NMN) MYERS</b>		14. MOTHER'S MAIDEN NAME <b>MARY HOLL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>212-16-5464</b>		17. INFORMANT <b>FAMILY</b>	
18. <b>171X I</b>		CAUSE OF DEATH <b>212</b>		ADDRESS <b>4926 GREENCREST AVE 6.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. If means the disease, injury or complication which caused death.) <b>GENERALIZED CARCINOMATOSIS</b>		(A) DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>CARCINOMA OF CERVIX</b>		<b>10 WMO</b>	
(C) DUE TO					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-1-1965</b> to <b>4-3-1965</b> , that (I) (we) last saw the deceased alive on <b>4-3-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Jacques E. Rioux M.D.</b>				23B. DATE SIGNED <b>4-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR JACQUES E. RIOUX M.D.</b>				23D. ADDRESS <b>WOMEN'S HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-6-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>MORELAND MEMORIAL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>R. G. E. ...</b>		25C. FUNERAL DIRECTOR <b>J. J. ...</b>	
ADDRESS <b>5444 BELAIR RD.</b>					



FUNERAL DIRECTOR: IMPORTANT

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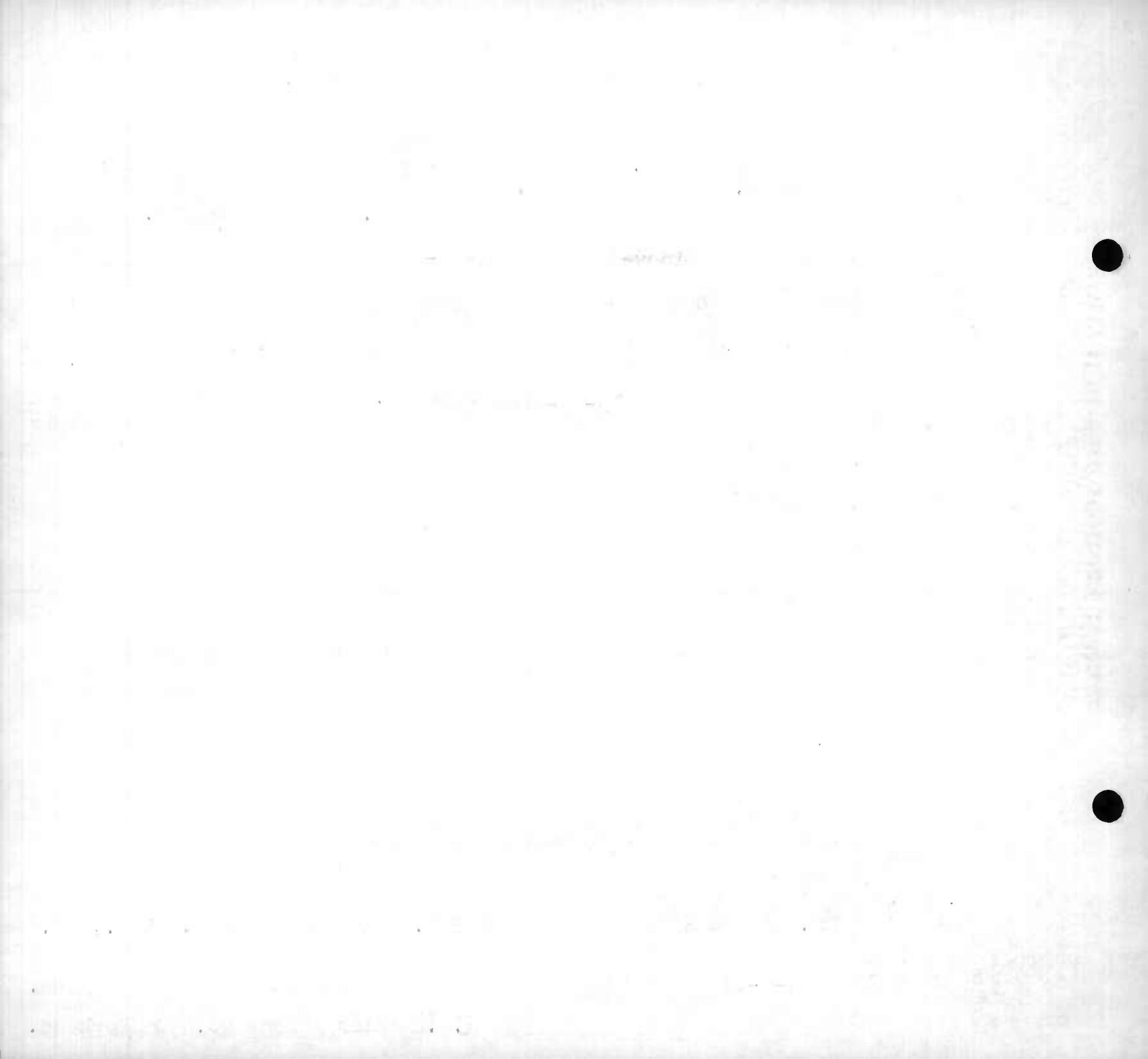
BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 3585					CERTIFICATE OF DEATH					Registered No. 65 3585				
1. NAME OF DECEASED (Type or Print) <i>Allen, Lawrence Vernon</i>					2. DATE AND HOUR OF DEATH <i>4-4-65</i> <i>5:20</i> <i>A.M.</i>									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Baltimore, Maryland</i> B. COUNTY									
FULL NAME OF HOSPITAL OR INSTITUTION <i>Lutheran Hospital of Maryland</i>					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					20-05				
					D. STREET ADDRESS (If rural, give location) <i>440 S. Smallwood St.</i>									
5. SEX <i>male</i>		6. RACE <i>white</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>MARRIED</i>		8. DATE OF BIRTH <i>5-12-1890</i>		9. AGE (In years lost birthday) <i>74</i>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>					11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>				
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					13. FATHER'S NAME <i>PETER RAY ALLEN</i>					14. MOTHER'S MARDEN NAME <i>MARY PITZENBERGER</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, give or unknown) (If yes, give war or dates of service) <i>NO</i>					16. SOCIAL SECURITY NO. <i>216-09-3000</i>					17. INFORMANT ADDRESS <i>LILLIAN M. ALLEN 410 S. Smallwood St</i>				
18. <i>586X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					CAUSE OF DEATH (A) <i>generalized peritonitis due to ruptured gall bladder.</i> (B) <i>severe electrolyte imbalance</i> (C) <i>possible C.V.A.</i>					INTERVAL BETWEEN ONSET AND DEATH <i>22 days</i>				
II														
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION <i>13-13-65</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>ruptured gall bladder</i>					20A. AUTOPSY? (Yes or No) <i>No</i>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <i>3-13-65</i> to <i>4-4-65</i> , that (I) (we) lost saw the deceased alive on <i>4-4-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <i>C.H. Paul Adib M.D.</i>										23B. DATE SIGNED <i>4-4-65</i>				
23C. PHYSICIAN'S NAME (Type) <i>C.H. Paul Adib</i>										23D. ADDRESS <i>Lutheran Hospital of Maryland</i>				
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>					24B. DATE <i>4-7-65</i>					24C. NAME OF CEMETERY or CREMATORY <i>London Park</i>				
24D. LOCATION <i>BALTIMORE, Md</i>					25A. DATE REC'D BY HEALTH DEPT. <i>APR 5 1965</i>					25B. NAME OF REGISTRAR <i>Robert E. Smith, M.D.</i>				
25C. FUNERAL DIRECTOR <i>650-45 Schwegel Funeral Home</i>					25D. ADDRESS <i>2101 Rudwick Ave.</i>									



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3586				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3586	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) HELEN PRIVETT WINSTEAD				2. DATE AND HOUR OF DEATH April 2, 1965 1 4 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ambassador Apts. 39th St. & Canterbury Rd.				A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) 12-01 D. STREET ADDRESS (If rural, give location) 39th St. & Canterbury Rd.			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 1-11-1882	9. AGE (In years lost birthday) 83	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Burkett Morris Privett				14. MOTHER'S MAIDEN NAME Mary Howard Leitner			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. B 212-03-8169		17. INFORMANT ADDRESS Thomas W. Winstead 2 Overlook Lane 10			
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) DUE TO Coronary Thrombosis (B) DUE TO (C) DUE TO INTERVAL BETWEEN ONSET AND DEATH 0							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Oct 12 1962 to March 2 1965, that (I) (we) lost saw the deceased alive on Sept 11 1964 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Joseph DB King				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 3/2/65	
23C. PHYSICIAN'S NAME (Type) Dr. Joseph King				23D. ADDRESS M.D. 222 W. Cold Spring Lane, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-5-65		24C. NAME OF CEMETERY or CREMATORY Druid Ridge		24D. LOCATION (City, town, or county) (State) Pikesville Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965		25B. NAME OF REGISTRAR R. E. Stedman		25C. FUNERAL DIRECTOR ADDRESS H. W. Jenkins & Sons Co. 4905 York Rd.			



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 3587</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>WILLIAMS, THOMAS E.</b>		2. DATE AND HOUR OF DEATH <b>APRIL 5, 1965 2:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSPITAL</b>		A. STATE <b>MD</b> B. COUNTY <b>2709</b>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
		D. STREET ADDRESS (If rural, give location) <b>1431 STONEWOOD Rd</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>10-4-1896</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED-MACHINIST</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>METAL</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>JOHN WILLIAMS</b>			14. MOTHER'S MAIDEN NAME <b>SARAH HOPKINS</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W.I.</b>		16. SOCIAL SECURITY NO. <b>220-01-1344</b>		17. INFORMANT <b>SARAH WILLIAMS</b>	
				ADDRESS <b>ABOVE</b>	
18. <b>450.01</b>		CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO <b>UREMIA AND ELECTROLYTE imbalance</b>			<b>MONTH</b>
ANTECEDENT CAUSES		(B) DUE TO <b>GENERALIZED ATHEROSCLEROSIS</b>			<b>YEARS</b>
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) _____			
<b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>3-23</b> 19 <b>65</b> to <b>4-5</b> 19 <b>65</b> , that (1) (we) last saw the deceased alive on <b>4-5</b> 19 <b>65</b> and that (1) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ephraim B. Barzaga</b> M.D.				23B. DATE SIGNED <b>4/5/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>EPHRAIM B. BARZAGA</b> M.D.		23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL - BALTO. MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>4-7-65</b>	24C. NAME OF CEMETERY or CREMATORY <b>PARKWOOD</b>		24D. LOCATION (City, town, or county) (State) <b>PARKVILLE MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>H. J. [unclear] &amp; Sons Co. 4905 York Rd</b>	

Mr. J. M. HOME & Co. 10-4-1872

John Williams  
Sarah Hopkins

Wm. A. and  
Sarah A. and  
Sarah A. and

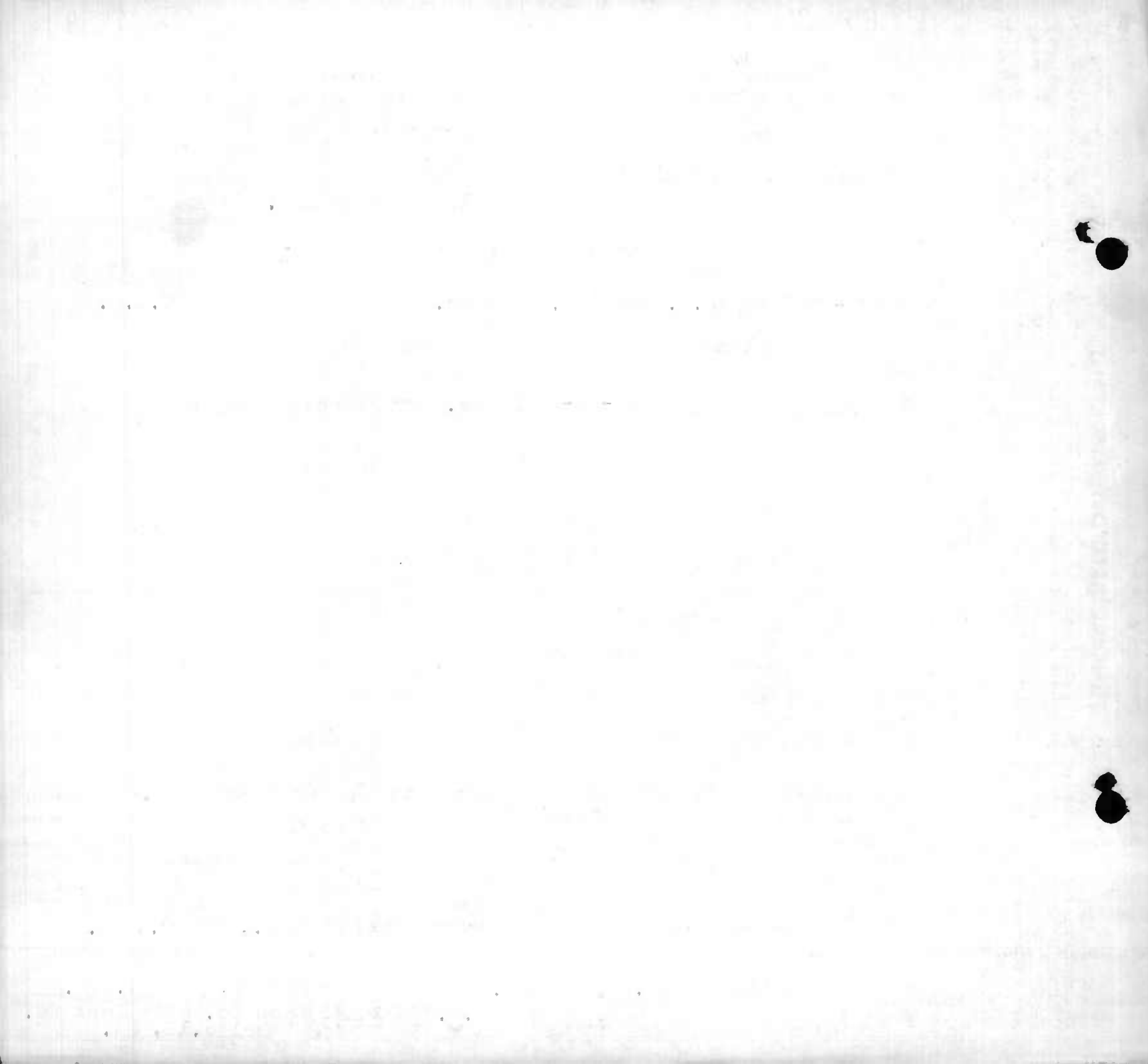
Ephraim B. Barker  
Charles Home



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 3588		CERTIFICATE OF DEATH		65 3588	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Claude W. Coleman		April 3 1965 5:05 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE B. COUNTY	
Church Home & Hospital				Maryland	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)	
				Baltimore	
				D. STREET ADDRESS (If rural, give location)	
				5115 Midwood Ave.	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (in years last birthday)	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
M	W	Married	2/8/1884	81	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Manager -Retired		J.C. Penny Co.		Mo.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Coleman			Unknown		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		236-01-4063		Mrs. Mary Frances Coleman (Same)	
18. 450.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) bronchopneumonia		days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) arteriosclerosis, generalized years			
		(C) thrombosis of common iliac artery and embolism on a popliteal artery			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from March 29 1965 to April 3 1965, that (X) (we) last saw the deceased alive on April 3 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE J. Howard Lutz				23B. DATE SIGNED Apr. 3, 1965	
23C. PHYSICIAN'S NAME (Type) J. HOWARD LUTZ				23D. ADDRESS Church Home & Hosp., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
Burial		4/7/1965		Mt. Olivet Cem.	
24D. LOCATION (City, town, or county) (State)		24E. FUNERAL DIRECTOR		24F. ADDRESS	
Parkersburg, W. Va.		H.W. Jenkins & Sons Co.		4905 York Rd. Balto. 12, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 5 1965		P. E. E. S. S. S.		H.W. Jenkins & Sons Co.	



R. 263

65 3589

BALTIMORE CITY HEALTH DEPARTMENT

65 3589

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES R. RICHARDS

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965

6:30 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

6240 Bellona Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6240 Bellona Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6/10/1889

9. AGE (In years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Purchasing-Retired

10B. KIND OF BUSINESS OR INDUSTRY

Bendix-Frieze

11. BIRTHPLACE (State or foreign country)

Baltimore, Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Randolph J. Richards

14. MOTHER'S MAIDEN NAME

Susan Tames

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

WW I

16. SOCIAL  
SECURITY NO.

215-09-1706

17. INFORMANT

Florence C. Richards

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/7/1965

23C. NAME of CEMETERY or CREMATORY

Friends Burial Ground

23D. LOCATION

(City, town, or county)

Baltimore,

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 5 1965

24B. NAME OF REGISTRAR

Rudiger E. Breitenecker

24C. FUNERAL DIRECTOR

H.W. Jenkins & Sons Co. 4905 York Rd.  
Balto. 12, Md.

WALLINGTON

W. W. W. W.

D. 250

65 3590

BALTIMORE CITY HEALTH DEPARTMENT

65 3590

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JULIAN DIXON

2. DATE AND HOUR PRONOUNCED DEAD

March 30, 1965

2:00 p. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Lutheran Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2734 Baker St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

6-29-1912

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Chauffeur

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Edward Dixon

14. MOTHER'S MAIDEN NAME

Jessie Stoner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

410

11-3-9-43

16. SOCIAL  
SECURITY NO.

233-12-0947

17. INFORMANT

ADDRESS

Lucille Dixon 2734 Baker St

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Lobar pneumonia  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Fatty metamorphosis of liver  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT NOT WHILE  
WORK AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐  
M.D. ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
3-31-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-5-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem

23D. LOCATION

(City, town, or county)

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

APR 5 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

Ragnar Sanders 217 E. Preston St

ADDRESS

WALLLEY POLICE

\_\_\_\_\_

W. J. Wallley  
Chief of Police  
Wallley, N. C.  
May 11, 1934

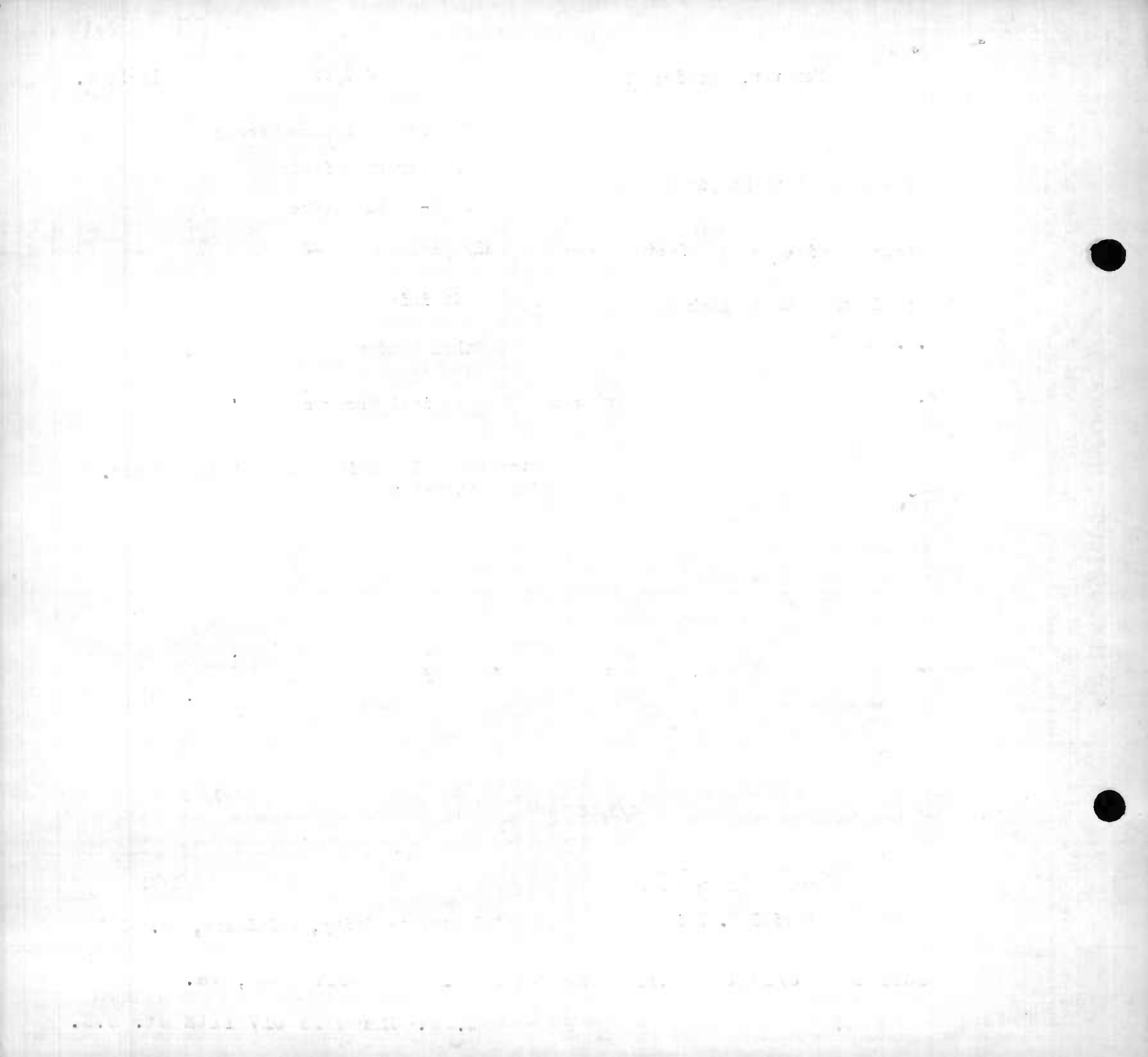
Enclosed for the  
Wallley Police  
Station



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 3591</b>		<b>CERTIFICATE OF DEATH</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3591</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Forquer, Mertice I</b>		2. DATE AND HOUR OF DEATH <b>4/1/65 10:50 A.</b>		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Montebello State Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Prince George</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Hillcrest Heights 66-00</b> D. STREET ADDRESS (If rural, give location) <b>5826- 28th Avenue</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED <b>WIDOWED, DIVORCED (specify)</b> <b>Widow</b>	8. DATE OF BIRTH <b>11/8/1918</b>	9. AGE (In years lost birthday) <b>46</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dry Cleaner Store Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>C.B. Morris</b>		14. MOTHER'S MAIDEN NAME <b>Ethel Tender</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		ADDRESS	
18. <b>171X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Squamous Cell Carcinoma of Cervix with Metastases</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) <b>Squamous Cell Carcinoma of Cervix with Metastases</b> DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>	
19A. DATE OF OPERATION <input type="radio"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/29/65</b> 19 to <b>4/1/65</b> 19, that (I) (we) last saw the deceased alive on <b>4/1/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Daniel G. Lai</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/1/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel G. Lai</b>		23D. ADDRESS M.D. <b>2201 Argonne Drive, Baltimore, Md. 21218</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>5/6/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Arlington National</b>		24D. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stokely</b>		25C. FUNERAL DIRECTOR <b>W. W. Chambers</b>		ADDRESS <b>517 11th St. S.E.</b>	





65 3592

BALTIMORE CITY HEALTH DEPARTMENT

65 3592

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN RUSS

2. DATE AND HOUR PRONOUNCED DEAD

April 2, 1965

4:10 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

City Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1413 N. Fremont Avenue

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Widower

8. DATE OF BIRTH

Aug 25-1916

9. AGE (In years  
last birthday)

50

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Labor

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Strommsville Md

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Albert Russ

14. MOTHER'S MAIDEN NAME

Lucy Meredith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

2983X

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fracture of neck  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Tavern

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

1361 N. Calhoun St.

21D TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
3 28 65 7:05p

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Involved in altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/7/1965

23C. NAME of CEMETERY or CREMATORY

Baltimore Nat Ch

23D. LOCATION

(City, town, or county)

Baltimore

(State)

Md

24A. DATE REC'D BY HEALTH DEPT.

APR 5 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

C. Williams &amp; Co. Inc.

ADDRESS

# VALLEY FORD

AND CONTENT

U.S.A.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3593		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3593	
1. NAME OF DECEASED (Type or Print) <b>ALPHONSO THIGPEN</b>			2. DATE AND HOUR OF DEATH <b>4/2/65 12:20 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>LUTHERAN HOSPITAL OF M.D.</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2804</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>709 WICKLOW ROAD</b>		
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>child</b>	8. DATE OF BIRTH <b>5-9-50</b>	9. AGE (In years lost birthday) <b>14</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Greenville N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Lorenzo Shigpen</b>			14. MOTHER'S MAIDEN NAME <b>Carrie Jones</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If Yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Chant</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>4-5/11</b>			CAUSE OF DEATH (A) <b>Prob. RUPTURED AORTA - ACUTE</b> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CONGENITAL HEART DISEASE</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4-2-65</b> 19 to <b>4-2</b> 19 <b>65</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>4-2</b> 19 <b>65</b> and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(we)</b> <b>(did)</b> (did not) view the body after death.					
23A. SIGNATURE <b>Renato R. Espina</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>RENATO R. ESPINA</b>		23D. ADDRESS <b>LUTHERAN HOSP. OF M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/6/1965</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Mt Calvary Ch</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 5 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Spivey</b>		25C. FUNERAL DIRECTOR <b>Chas W. Allen</b> ADDRESS <b>1000 Broadway Ave</b>	

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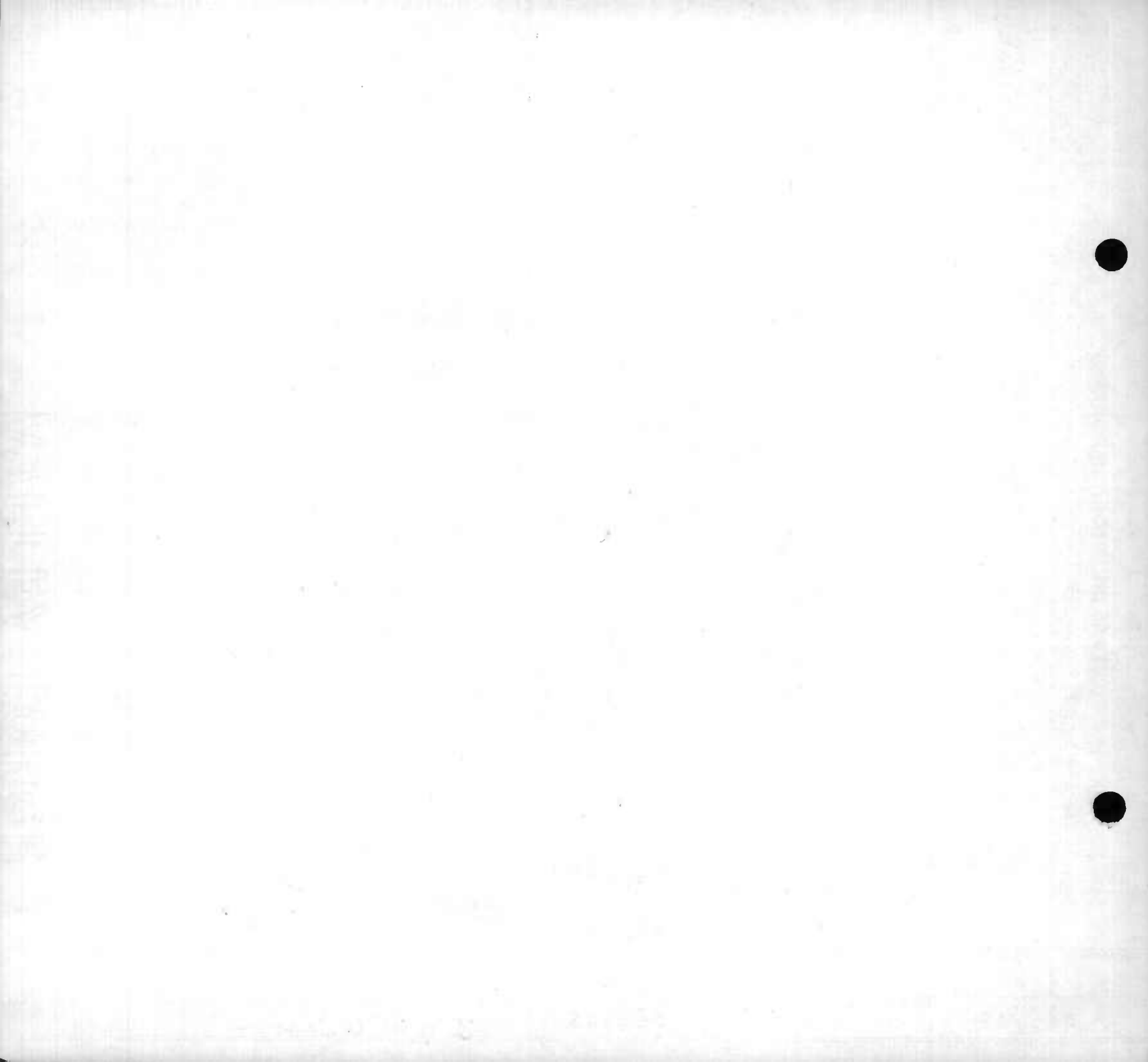
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

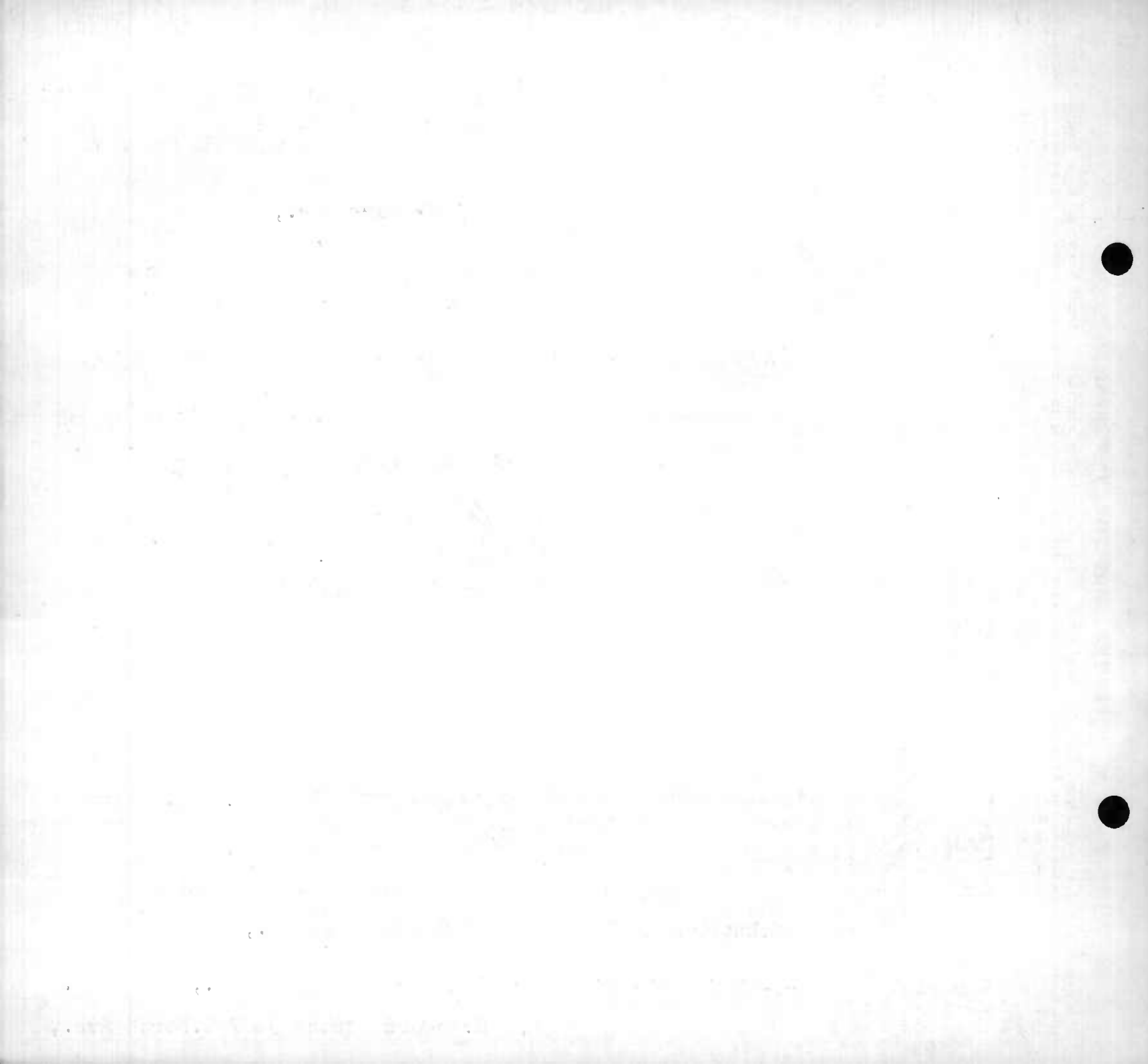
BIRTH NO. 65 3594				BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3594			
M.E. CASE NO.				CARR				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Mrs. Christy Carr (Mary)				2. DATE AND HOUR OF DEATH April 2, 1965 14:20 A.M.							
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE B. COUNTY							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bon Secours Hospital 2025 West Fayette St				C. CITY OR TOWN (If outside city limits, write RURAL and give township) 2345 W. Lexington St.							
D. STREET ADDRESS (If rural, give location) Baltimore 21223											
5. SEX F		6. RACE Colored		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married		8. DATE OF BIRTH 2-12-1900		9. AGE (In years lost birthday) 65		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Andrew White				14. MOTHER'S MAIDEN NAME Mary Roberts							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 420.1 I Myocardial infarction with congestive heart failure				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) DUE TO							
				(B) DUE TO							
				(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from 3-21-65 19 to 4-2 1965, that (I) (we) lost saw the deceased alive on 4-2-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE Crispin C. Linantud, Jr.								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-2-65	
23C. PHYSICIAN'S NAME (Type) CRISPIN C. LINANTUD, JR.								M.D. 23D. ADDRESS BON SECOURS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 4/6/1965		24C. NAME of CEMETERY or CREMATORY Dames Guenther		24D. LOCATION (City, town, or county) (State) Dames Guenther Md					
25A. DATE REC'D BY HEALTH DEPT. APR 5 1965				25B. NAME OF REGISTRAR Robert E. Stachura		25C. FUNERAL DIRECTOR C. C. Wilson		ADDRESS			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>65-08124</u> <u>65</u> <u>3595</u> <b>CERTIFICATE OF DEATH</b>		Registered No. <u>65</u> <u>3595</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY Girl "C" GRAHAM</u>	
2. DATE AND HOUR OF DEATH <u>4-2-65</u> <u>16:20 P.M.</u>		3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>LUTHERAN HOSPITAL OF MD. Inc.</u>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>27-44</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>	
D. STREET ADDRESS (If rural, give location) <u>3821 Mary Ave.,</u>		5. SEX <u>Female</u> 6. RACE <u>WHITE</u>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>N/A</u>		8. DATE OF BIRTH <u>3/31/65</u> 9. AGE (In years last birthday) <u>1</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK CARROLL GRAHAM</u>		14. MOTHER'S MAIDEN NAME <u>JOAN MADLYN HARDESTY</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>N/A</u>		16. SOCIAL SECURITY NO. <u>N/A</u>	
17. INFORMANT <u>Mother -</u>		ADDRESS <u>3821 Mary Avenue</u>	
18. <u>760.51</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) DUE TO <u>① Birth injury to the brain?</u> (B) DUE TO <u>② Prematurity</u> (C) <u>③ Cerebral Hemorrhage</u>	
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>3/31/65</u> 19 <u>65</u> to <u>4-2-65</u> 19 <u>65</u> that (I) (we) last saw the deceased alive on <u>4/2/65</u> <u>6:20 PM</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Milani</u> M.D.		23B. DATE SIGNED <u>4-2-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Mokhtar Milani</u> M.D.		23D. ADDRESS <u>730 Ashburton St.,</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-3-1965</u>	
24C. NAME of CEMETERY or CREMATORY <u>Lake View Memorial Park</u>		24D. LOCATION (City, town, or county) (State) <u>Carroll Co., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 5 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Stachurski</u>	
25C. FUNERAL DIRECTOR <u>G. Howard Strong</u>		ADDRESS <u>3207 W. North Ave.,</u>	

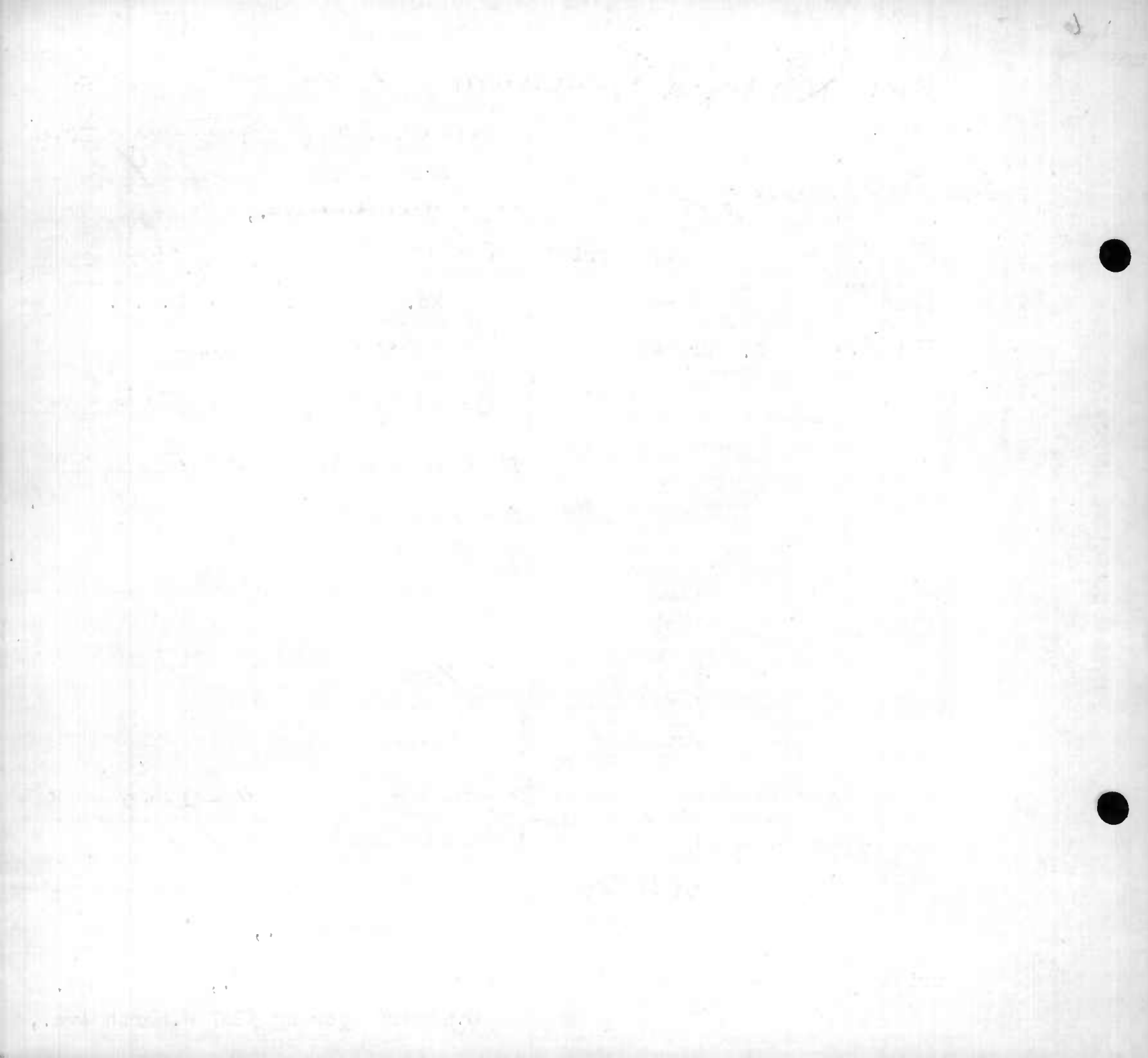




FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 3596				
BIRTH NO. 65-08123		65 3596							
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>IV-1 B. Triplets Graham</i>			2. DATE AND HOUR OF DEATH <i>4-2-65 6:45 M.</i>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE			B. COUNTY		
<i>Lutheran Hospital at MD.</i>				<i>Maryland</i>			<i>Sutherland Hosp.</i>		
				C. CITY OR TOWN (In outside city limits, write RURAL and give township)					
				<i>Baltimore</i>			<i>27-44</i>		
				D. STREET ADDRESS (If rural, give location)					
				<i>3821 Mary Ave.,</i>					
5. SEX <i>F.</i>	6. RACE <i>W.</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>		8. DATE OF BIRTH <i>3-31-65</i>		9. AGE (In years last birthday)		10. If Under 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
<i>None</i>		<i>==</i>		<i>Md.</i>		<i>U.S.A.</i>			
13. FATHER'S NAME <i>FRANK C. Graham</i>				14. MOTHER'S MAIDEN NAME <i>MADYNN. Hardesty</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT ADDRESS <i>3821 Mary Ave Baltob, 1965</i>			
18. <i>761.5T</i>				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) <i>① Thrombophlebitis</i>					
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(B) <i>② Prematurity</i>					
ANTECEDENT CAUSES				(C) <i>③ Birth injury</i>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from <i>3-31-65</i> 19 to <i>4-2-65</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4-2-65 6:45</i> 19 <i>45</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <i>Milani</i> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4-2-65</i>			
23C. PHYSICIAN'S NAME (Type) <i>MOKHTAR MILANI</i>				23D. ADDRESS <i>730 Ashburton St.,</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-3-1965</i>		24C. NAME of CEMETERY or CREMATORY <i>Lakeview Memorial Park</i>		24D. LOCATION (City, town, or county) <i>Carroll Co.,</i>		(State) <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 5 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Stuber</i>		25C. FUNERAL DIRECTOR <i>G. Howard Strong</i>		ADDRESS <i>3207 W. North Ave.,</i>			



65 3597

BALTIMORE CITY HEALTH DEPARTMENT

65 3597

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARSHALL DISTELL

2. DATE AND HOUR PRONOUNCED DEAD

4/1/65 2:24 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1301 W. Baltimore St.

5. SEX  
male6. RACE  
white7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan. 16, 1897

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Carpenter

10B. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (State or foreign country)

Ohio

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

302 03 7888

17. INFORMANT

ADDRESS

Gerald Distel, 1301 W. Baltimore St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

W. U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/2/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Apr. 5, 1965

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Talley, M.D.

24C. FUNERAL DIRECTOR

Thomas J. Kenny, Inc. 1600 Hollins St.

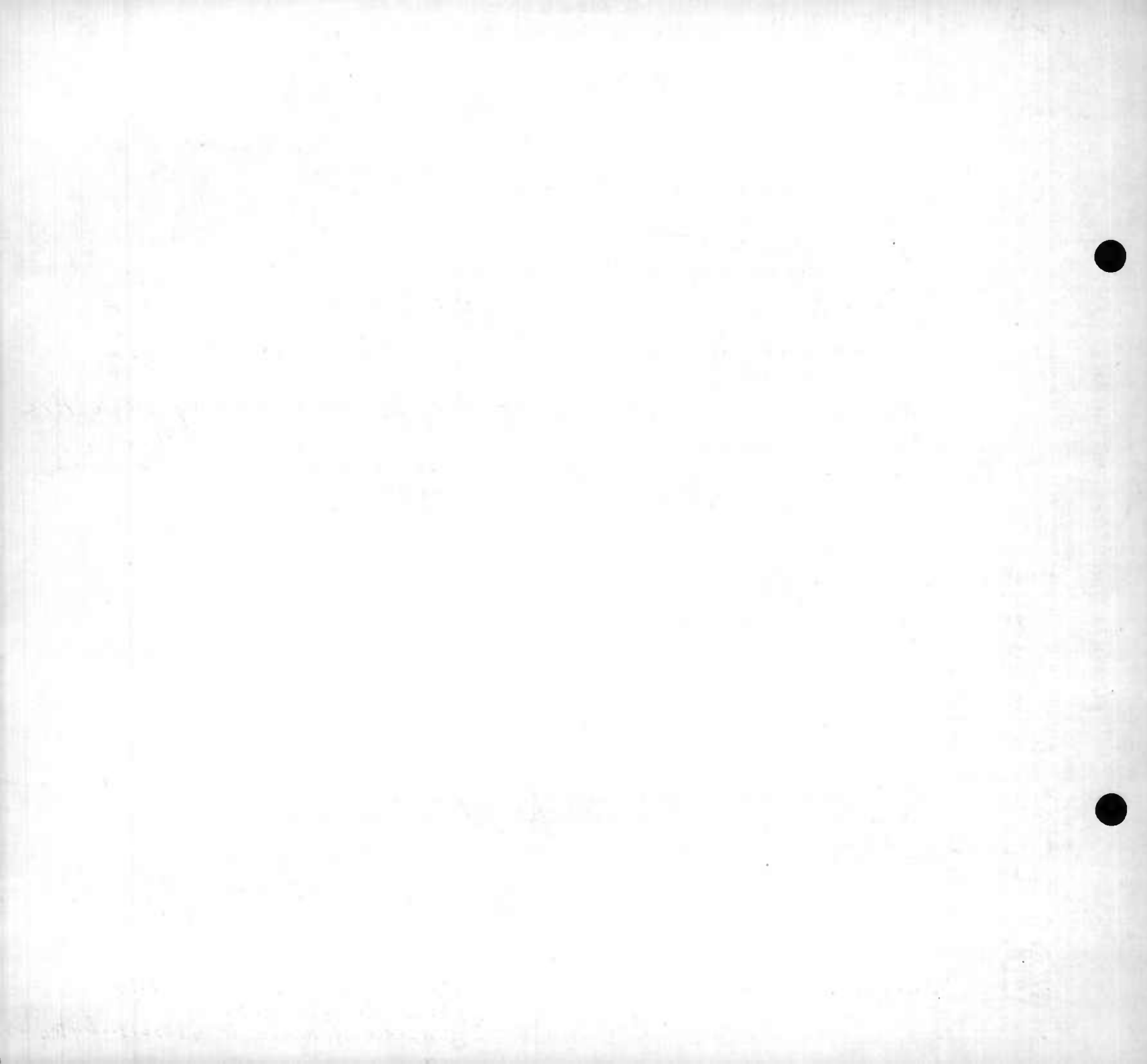
ADDRESS

John and

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3598		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3598	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MENNE-John-George		2. DATE AND HOUR OF DEATH 4/3/65 10:25 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 42 SINAI-HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY Balto C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE D. STREET ADDRESS (If rural, give location) 5308 Gwynndale Ave, #7			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 1/27/92	9. AGE (In years lost birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) P.R.R.		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herman Menne		14. MOTHER'S MAIDEN NAME Babette Munke	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 717-07-8234A		17. INFORMANT Mary Menne 5308 Gwynndale Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 163X I CAUSE OF DEATH (A) Ca of the lung with metastasis to Brain. (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 5 MONTHS?			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/16/65 to 4/3/65, that (I) (we) last saw the deceased alive on 4/3/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.					
23A. SIGNATURE Aron Ary		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/3/65	
23C. PHYSICIAN'S NAME (Type) ARON-ARY		23D. ADDRESS SINAI-HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/65		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
24D. LOCATION Baltimore Md.					
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR William H. Armstrong	
				ADDRESS 4600 Liberty Heights	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3599				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3599	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DOHERTY, GEORGE</b>				2. DATE AND HOUR OF DEATH <b>4-5-65 2:00 A.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>16-08</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home &amp; Hospital</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 29</b>			
5. SEX <b>M</b> 6. RACE <b>W</b> 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>				D. STREET ADDRESS (If rural, give location) <b>1303 Wildwood Parkway</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>retired</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beld Brass Co</b>		11. BIRTHPLACE (State or foreign country) <b>Connecticut</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>James Doherty</b>			
14. MOTHER'S MAIDEN NAME <b>Bessie Hill</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>215-09-1448</b>			
16. SOCIAL SECURITY NO. <b>215-09-1448</b>				17. INFORMANT <b>Bessie Doherty</b> ADDRESS <b>1303 Wildwood Parkway</b>			
18. <b>422.11</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) <b>Cardiovascular shock</b> <b>several hours</b>			
ANTECEDENT CAUSES				(B) <b>Diffuse arteriosclerosis</b> <b>years</b>			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) <b>Senility</b> <b>years</b>			
II				OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>2-12-65</b> 19 to <b>4-5-65</b> 19 that (I) (we) last saw the deceased alive on <b>4/5/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Cesar R. Bariso</b> M.D.				23B. DATE SIGNED <b>4/5/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>CESAR R. BARISO</b> M.D.				23D. ADDRESS <b>Church Home &amp; Hospital - Balto. 31, Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>4/7/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Riverside Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Waterbury Conn.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>R. B. E. Scott</b>		25C. FUNERAL DIRECTOR <b>Edw. J. Macrost</b>		ADDRESS <b>400 Liberty St.</b>	







T. 460

65 3600

BALTIMORE CITY HEALTH DEPARTMENT

65 3600

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELLSWORTH

TAYLOR

2. DATE AND HOUR PRONOUNCED DEAD

April 1, 1965

2:20 P

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1700 Linden Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

3/9/04

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cutod lan

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore Md

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Unknown

14. MOTHER'S MAIDEN NAME

Carrie

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs Anna Handy 2831 Spellman Rd

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/1/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/8/65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Adolphus Halstead 918 Druid Hill Ave

ADDRESS

WALLLEY BARRAGE

L 520

BALTIMORE CITY HEALTH DEPARTMENT				65 3601			
BIRTH NO.				65 3601			
M.E. CASE NO.				65 3601			
1. NAME OF DECEASED (Type or Print)		SISCO		2. DATE AND HOUR PRONOUNCED DEAD		4-4-65 6:45 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		ROBERT A LONG		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		Maryland	
FULL NAME OF DECEASED (If not in hospital or institution, give street address or location)		UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		Baltimore	
				D. STREET ADDRESS (If rural, give location)		2305 Eutaw Place	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		
Male	Colored	Single	3-5-30	10-25-31	-34 33		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Laborer				North Carolina			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		17. INFORMANT ADDRESS			
Brinkly Long		Anna		Mrs Rosa Coles 2305 Eutaw Place			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
		241-42-6495					
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  CORONARY OCCLUSION - Complicating HYPERTENSIVE CARDIOVASCULAR DISEASE							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2				Yes		Yes	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]		21F. HOW DID INJURY OCCUR?			
22. I certify that I held an Inquiry [ ] Inspection [ ] Autopsy [X] and that on this basis, death in my opinion resulted from: Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER [ ]			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER [ ]			
PETER W. RIECKERT, M.D.				ASSOCIATE MEDICAL EXAMINER [X]			
23A. BURIAL CREMATION, REMOVAL (Specify)		23B. DATE		23C. NAME of CEMETERY or CREMATORY		23D. LOCATION (City, town, or county) (State)	
Burial		4/9/65		Whitesville		North Carolina	
24A. DATE REC'D BY HEALTH DEPT.		24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR		ADDRESS	
APR 6 1965		Adolphus Halstead		Adolphus Halstead		918 Druid Hill Ave	

Birth Cert. from North Carolina for

Robert Sisco Long born 10-25-1931.

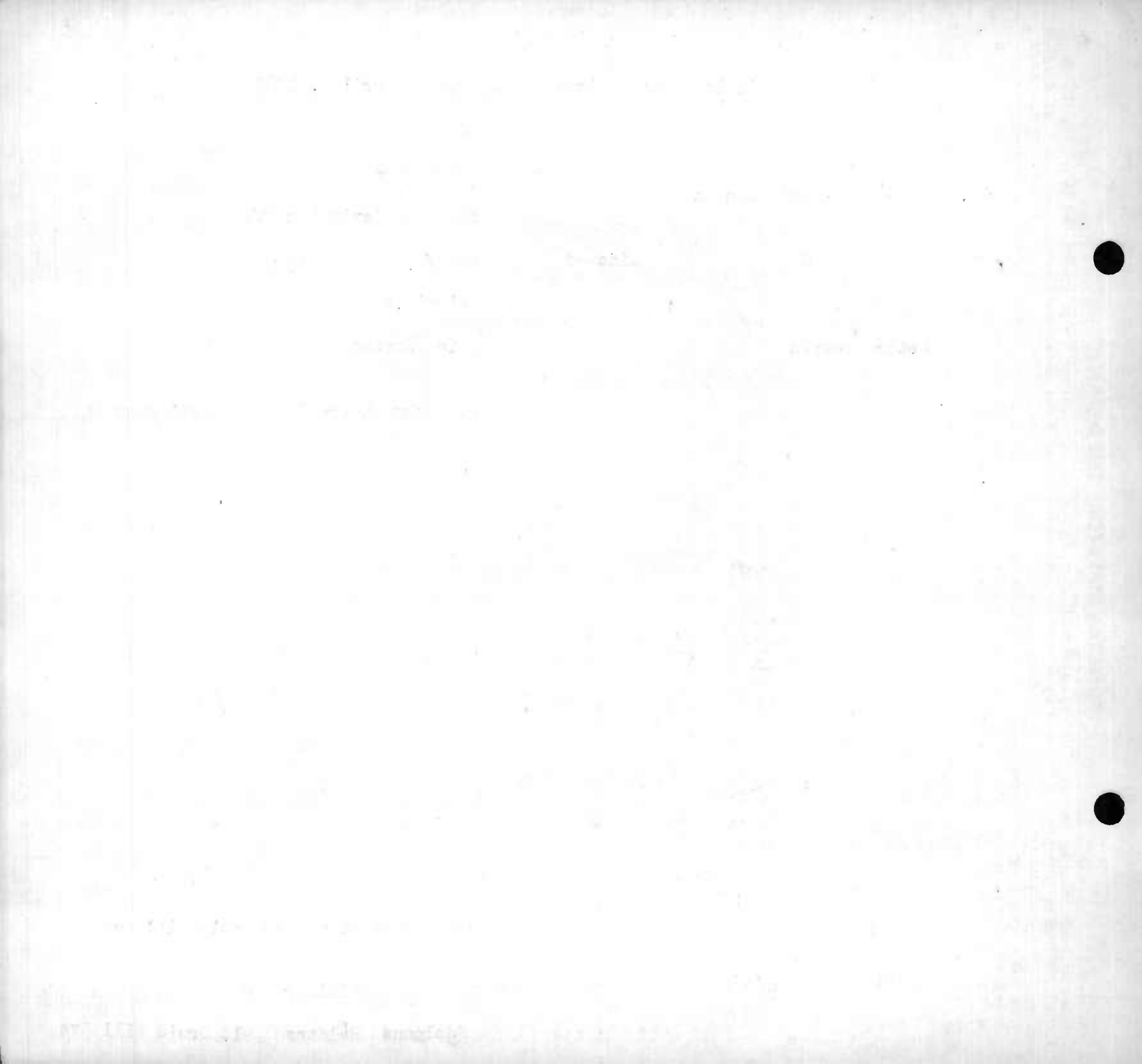
4-14-65 M.H.

Black J. J.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3602				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 3602	
M.E. CASE NO. 65 3602				1. NAME OF DECEASED (Type or Print) <b>Willie Mae Hicks (Boykins)</b>		2. DATE AND HOUR OF DEATH <b>April 2, 1965</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>1953 W Lexington St</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ma</b> B. COUNTY <b>2001</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1953 W Lexington St</b>					
5. SEX <b>F</b>	6. RACE <b>C</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>9/10/08</b>	9. AGE (In years last birthday) <b>56</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Peter Boston</b>			14. MOTHER'S MAIDEN NAME <b>Rosie Boston</b>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs Ruby Harrell 1953 W Lexington St</b>				
18. <b>260X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Coronary Insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Heart Disease 2 yrs</b> <b>Diabetes Mellitus 5 yrs.</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>November 1960</b> to <b>April 2 1965</b> , that (I) (we) last saw the deceased alive on <b>April 1st 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Percival C. Smith</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4-5-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Percival C. Smith</b>				23D. ADDRESS <b>Adolphus Halstead 918 Druid Hill Ave</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Adolphus Halstead 918 Druid Hill Ave</b>					

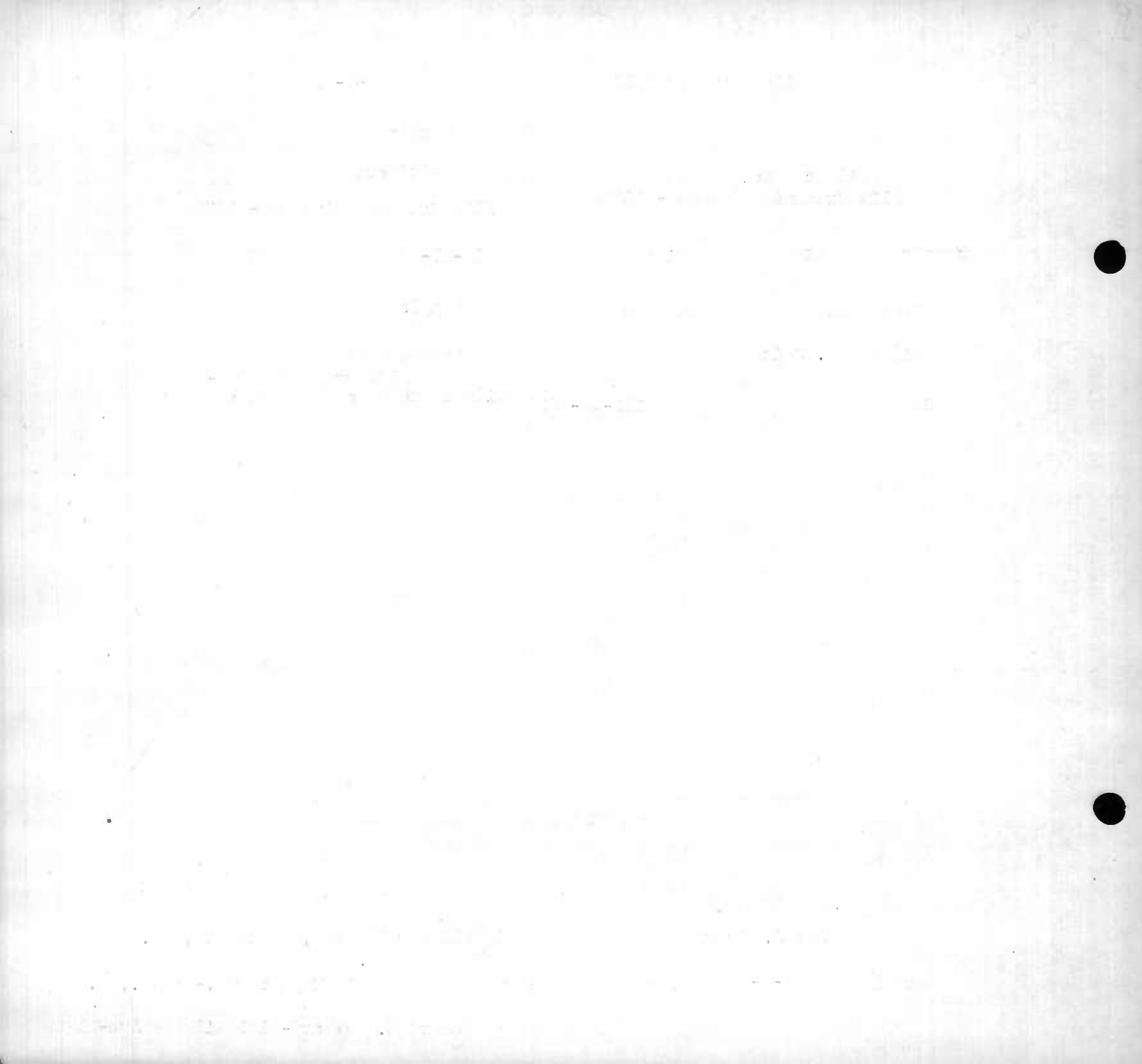




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3603				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3603	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Ella May Russell				2. DATE AND HOUR OF DEATH 4-2-65 6:50 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Silver Cross Home 5124 Greenwich Avenue - 21229				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 5124 Greenwich Avenue - 21229			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widow	8. DATE OF BIRTH 12-17-84	9. AGE (In years last birthday) 80	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10B. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William B. Smith				14. MOTHER'S MAIDEN NAME Maggie Schauman			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-1834		17. INFORMANT 5124 Greenwich Ave-29 Silver Cross Home Hospital Records			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH I. <u>Arteriosclerosis, Generalized</u> DUE TO II. <u>unknown</u> DUE TO DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH			
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan 1965 to April 1965, that (I) (we) last saw the deceased alive on April 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Leo J. Gaver</i> Leo J. Gaver				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/3/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D. 1 Mallow Hill Road, Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-5-65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery		24D. LOCATION (City, town, or county) (State) 3310 Taylor Ave.-Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR <i>Robert E. Stanley</i>		25C. FUNERAL DIRECTOR ADDRESS Howard H. Hubbard-4107 Wilkens Ave-21229			

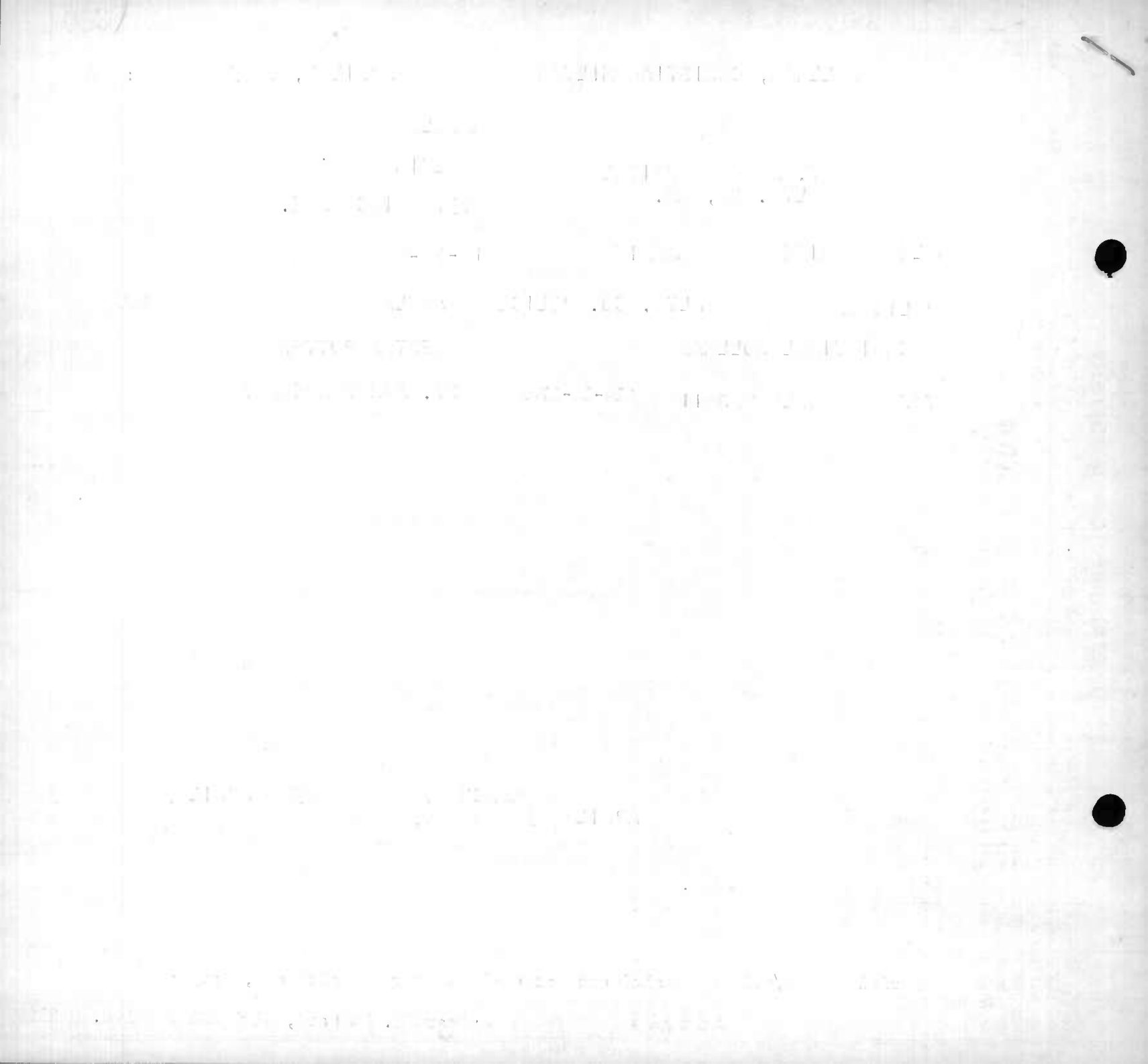




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65 3604</u>	
BIRTH NO. <u>65 3604</u>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <u>APRIL 3, 1965</u>   <u>6:20A</u> M.	
1. NAME OF DECEASED (Type or Print) <u>ROLLMAN, CHRISTIAN MILTON</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  <u>ST. AGNES HOSPITAL</u> <u>BALTO. 29, MD.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Balto</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE 27</u> D. STREET ADDRESS (If rural, give location) <u>1319 BIRCH AVE.</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>12-30-20</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>BALTO. CO. POLICE</u>	9. AGE (In years last birthday) <u>44</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHRISTIAN L ROLLMAN</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA POTTER</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WAR II</u>		16. SOCIAL SECURITY NO. <u>214-14-1705</u>	
17. INFORMANT <u>ST. AGNES RECORDS</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  <u>Cancer of Pancreas</u>		INTERVAL BETWEEN ONSET AND DEATH	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
21A. DATE OF OPERATION <u>0</u>	21B. CONDITION FOR WHICH OPERATION WAS PERFORMED	21C. WHERE DID INJURY OCCUR? <u>NO</u>	21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	21D. HOW DID INJURY OCCUR?
21E. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21F. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
22. I certify that (I) (this hospital) attended the deceased from <u>MARCH 27</u> 19 <u>65</u> to <u>APRIL 3</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>APRIL 3</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Henry R. Verbergh</u>			23B. DATE SIGNED <u>4-3-65</u>
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>4/6/1965</u>	24C. NAME of CEMETERY or CREMATORY <u>Baltimore National Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1965</u>	25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	25C. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>	ADDRESS <u>4107 Wilkens Ave. # 21229</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3605		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3605	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Harper, Bryan William		2. DATE AND HOUR OF DEATH 4/2/65 1340 P.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION University Hospital		A. STATE Md.		B. COUNTY Howard	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN Elkridge		(If outside city limits, write RURAL and give township) 63-00	
		D. STREET ADDRESS 1715 Montgomery Rd.		(If rural, give location)	
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 2/24/00	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10B. KIND OF BUSINESS OR INDUSTRY Barcelona Distributing + Pkg Co.		11. BIRTHPLACE (State or foreign country) W. Va.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Semore Harper		14. MOTHER'S MAIDEN NAME Sally Ours	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 216-32-7843		17. INFORMANT Mrs. Gwendolyn S. Harper Robert E. Stoner, MD	
18. 230X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) Post Operative Peritonitis DUE TO		INTERVAL BETWEEN ONSET AND DEATH 25 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO			
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION March 8, 1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Colonic Polyp		20A. AUTOPSY? (Yes or No) No	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 4/1 1965 to 4/2 1965, that (II) (we) last saw the deceased alive on 4/2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (II) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Robert E. Stoner, MD		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/2/65	
23C. PHYSICIAN'S NAME (Type) Robert E. Stoner		23D. ADDRESS University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-5-65		24C. NAME of CEMETERY or CREMATORY Grace Cemetery	
24D. LOCATION (City, town, or county) (State) Elkridge, Maryland		25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. Stoner	
25C. FUNERAL DIRECTOR Howard H. Hubbard		25D. ADDRESS 4107 Wilkens Ave-21229			

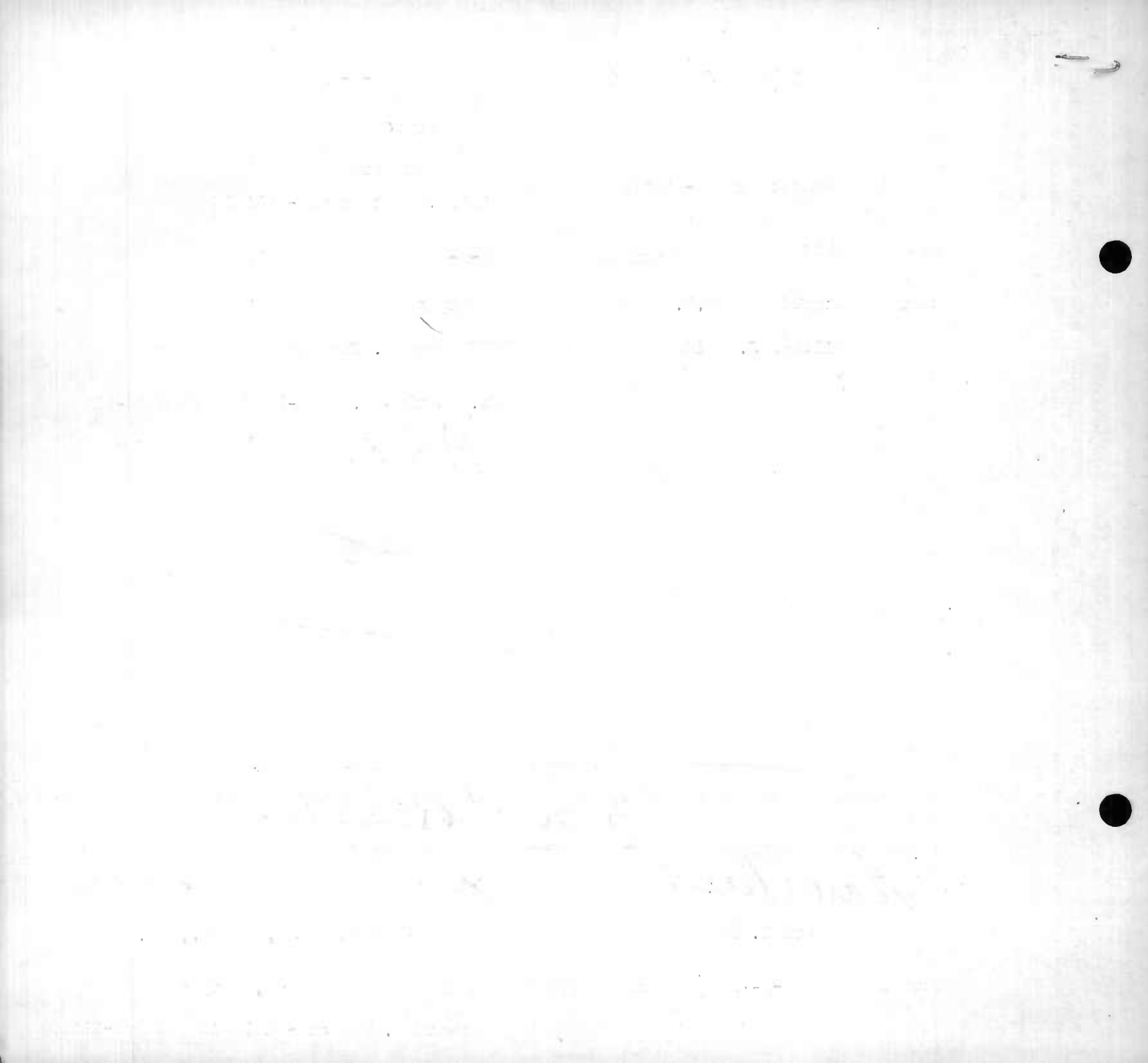
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 3606	
BIRTH NO. 65 3606		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) William James Reid		2. DATE AND HOUR OF DEATH 4-2-65	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  2823 Sunset Drive - 21223				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2006 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 2823 Sunset Drive - 21223			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 4-9-89	9. AGE (In years lost birthday) 75	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk Retired		10B. KIND OF BUSINESS OR INDUSTRY L.A. Benson		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William J. Reid				14. MOTHER'S MAIDEN NAME Sara E. Franklin			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Charles R. Reid-1800 Hanford Rd-21206			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				(A) DUE TO ASCVD		INTERVAL BETWEEN ONSET AND DEATH 3	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from April 1965 to 4-2-1965, that (I) (we) last saw the deceased alive on 3-20-1965 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Earl I. Pass				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4-3-65	
23C. PHYSICIAN'S NAME (Type) Earl I. Pass				23D. ADDRESS 4001 Wilkens Avenue, Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-5-65		24C. NAME of CEMETERY or CREMATORY Lorraine Park Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR R. E. Bailey		25C. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave-21229	

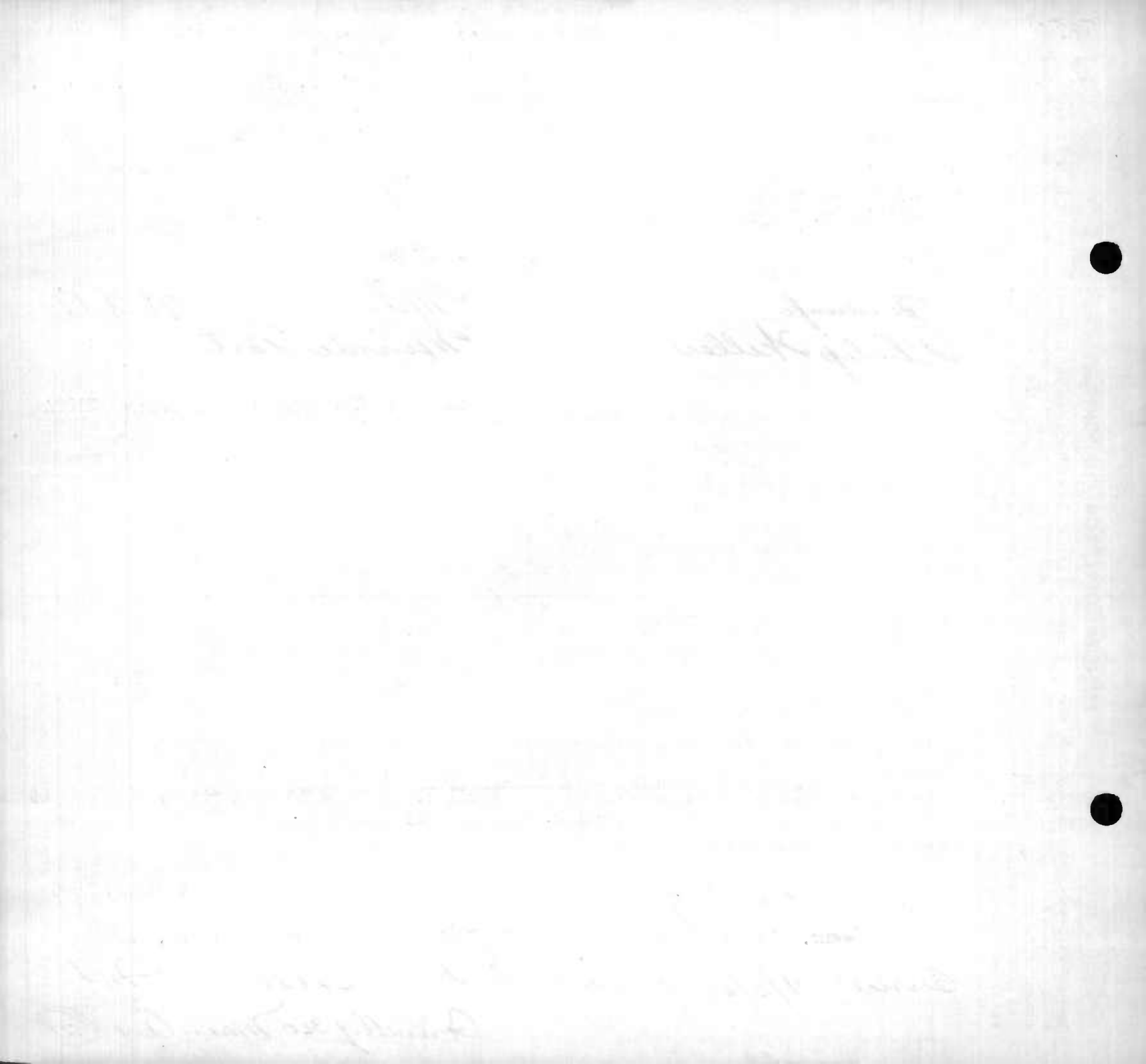


43-23-81

## FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3607	
BIRTH NO. 65 3607		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Katherine Durdin		2. DATE AND HOUR OF DEATH April 2, 1965 8:15 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland, 21224		C. CITY OR TOWN (If outside city limits, write RURAL and give township) RURAL: 53-00 D. STREET ADDRESS (If rural, give location) 108 Kingston Park Road			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 2-13-1886	9. AGE (In years last birthday) 79	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Philip Keller		14. MOTHER'S MAIDEN NAME Minnie Fort	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH: 4940 Eastern Avenue #21224	
18. 570.21 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Mesenteric Vascular Occlusion 2 days		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from April 2, 19 65 to April 2, 19 65, that (I) (we) last saw the deceased alive on April 2, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Richard Lane		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 2, 1965	
23C. PHYSICIAN'S NAME (Type) Dr. Richard Lane		23D. ADDRESS M.D. 4940 Eastern Avenue Baltimore, Maryland			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/65		24C. NAME OF CEMETERY or CREMATORY Landon Park	
24D. LOCATION (City, town, or county) (State) Baltimore Md.		25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR R. E. Staley	
25C. FUNERAL DIRECTOR 300 Waver Ave. (21)		25D. ADDRESS			

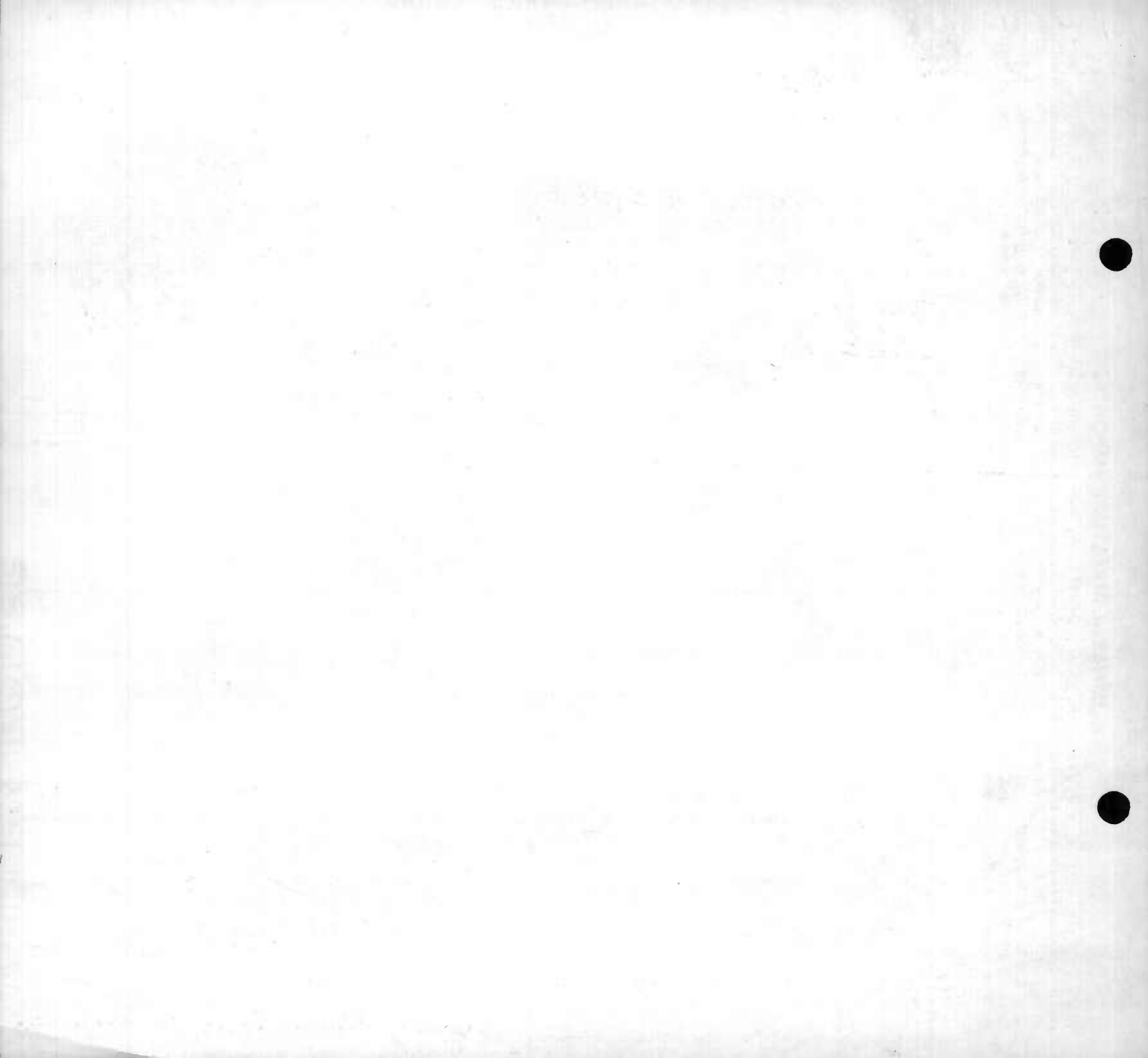




# FUNERAL DIRECTOR: IMPORTANT

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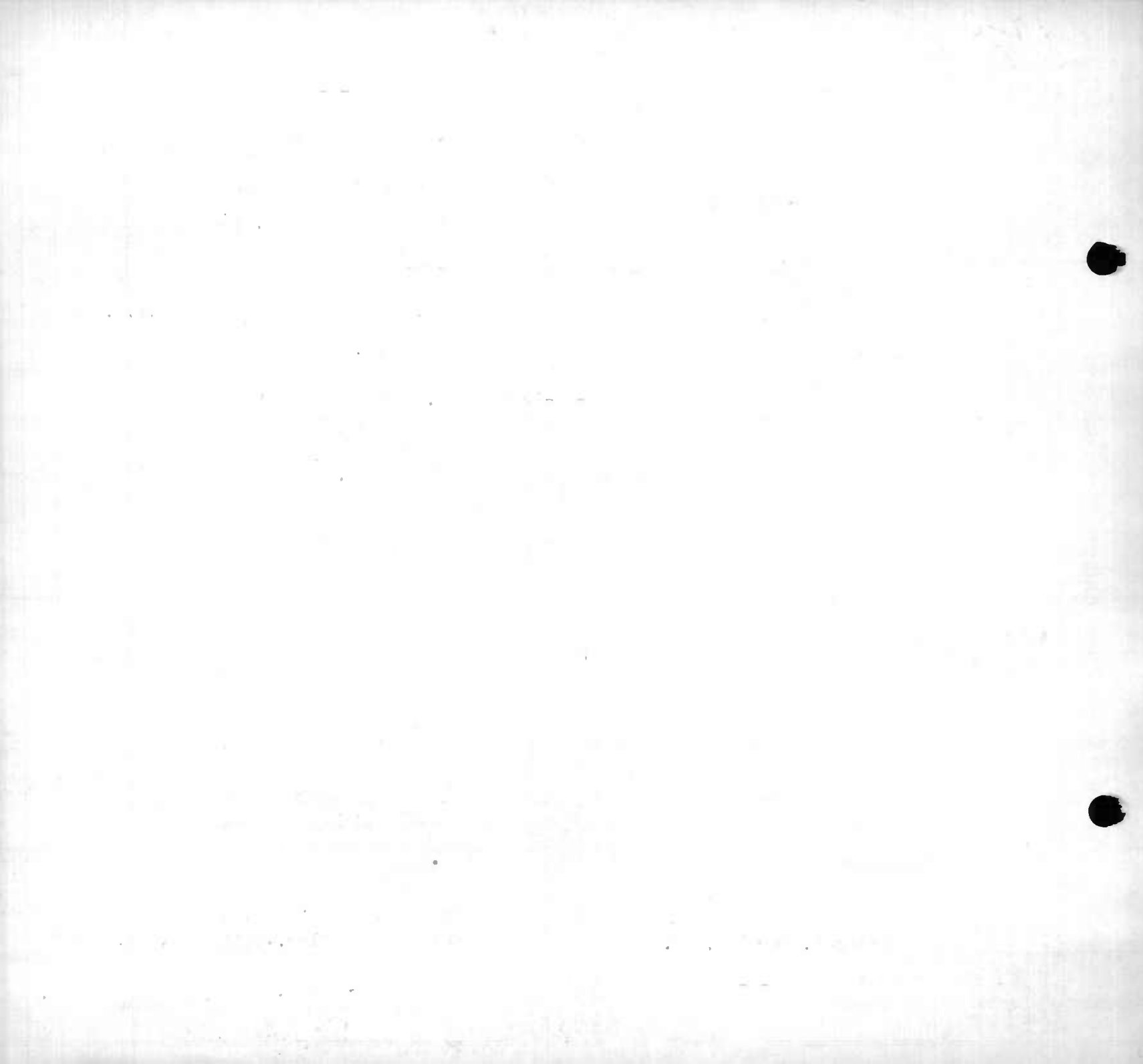
BIRTH NO. 65 3608		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3608	
M.E. CASE NO.		CERTIFICATE OF DEATH		1. NAME OF DECEASED (Type or Print) Miller, Evelyn	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		4/2/65 5:40 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		A. STATE Md. B. COUNTY Balto	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Rural (Essex) 5300	
Sinai Hospital of Balto.		D. STREET ADDRESS (If rural, give location)		14 Langley Rd #20	
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) M	8. DATE OF BIRTH 12/10/22	9. AGE (In years last birthday) 42	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		at Home		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Albert Perry		Grady		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				Charles G. (Husband) same as above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Bronchopneumonia	
ANTECEDENT CAUSES		(B) DUE TO		Lung Metastases	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		Ca of Cervix	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES	
2				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 4/1 19 65 to 4/2 19 65, that (I) (we) last saw the deceased alive on 4/2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/2/65	
23C. PHYSICIAN'S NAME (Type) Thomas L. Feher		M.D. 23D. ADDRESS		Sinai Hospital, Balto	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 5-1965		24C. NAME OF CEMETERY OR CREMATORY Hyndman Cemetery Bedford Co. Penna	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR R. C. E. Taylor		25C. FUNERAL DIRECTOR ADDRESS	
				O'Donnell Funeral Home 300 Mace Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

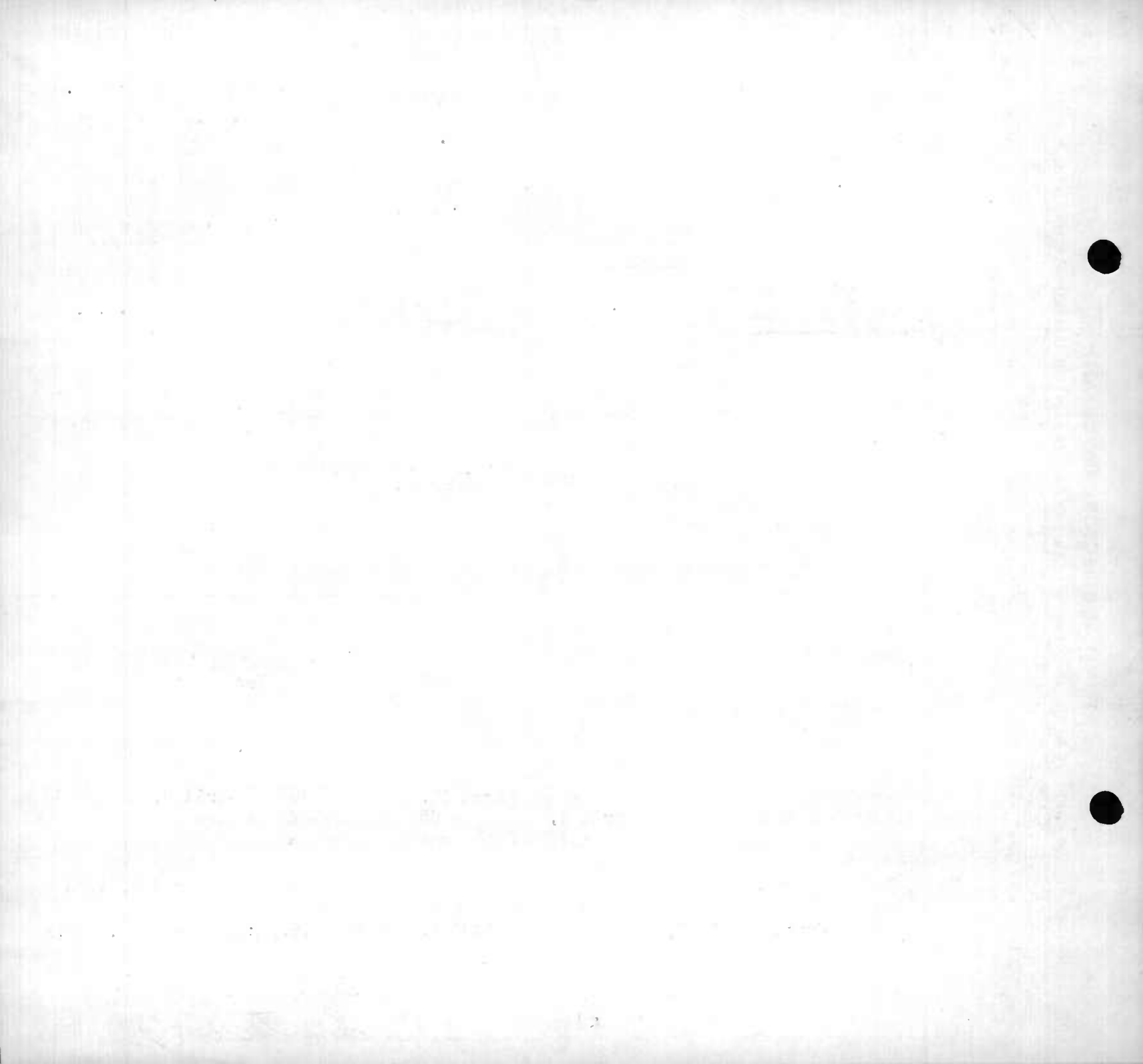
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 3609		CERTIFICATE OF DEATH		Registered No. 65 3609	
1. NAME OF DECEASED (Type or Print) <b>Arthur Roland Davis</b>				2. DATE AND HOUR OF DEATH <b>8-3-65</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Gould Nursing Home</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>620 Parkwyth Ave. 18</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>4-21-83</b>	9. AGE (In years last birthday) <b>82</b>	If Under 1 Yr. Months: Days: Hours: Min.		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>		
10B. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Md.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Davis</b>			14. MOTHER'S MAIDEN NAME <b>Mary Ness</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-07-3267</b>			17. INFORMANT <b>Mr. Carl LaMont</b>			ADDRESS <b>620 Parkwyth Ave.</b>			
18. <b>422.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic Cardiovascular Disease</b>				(A) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO					
(C) DUE TO									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>1950</b> to <b>April 3</b> 19 <b>65</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 2</b> 19 <b>65</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>We</del> ) ( <del>did</del> ) (did not) view the body after death.									
23A. SIGNATURE <b>Thomas L. Worsley, Jr.</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>April 5 1965</b>			
23C. PHYSICIAN'S NAME (Type) <b>Thomas L. Worsley, Jr.</b>				23D. ADDRESS <b>2900 Alameda Blvd. Baltimore, Md. 21218</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Balt. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Sub E Bennett</b>		ADDRESS <b>3615 Belmont</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

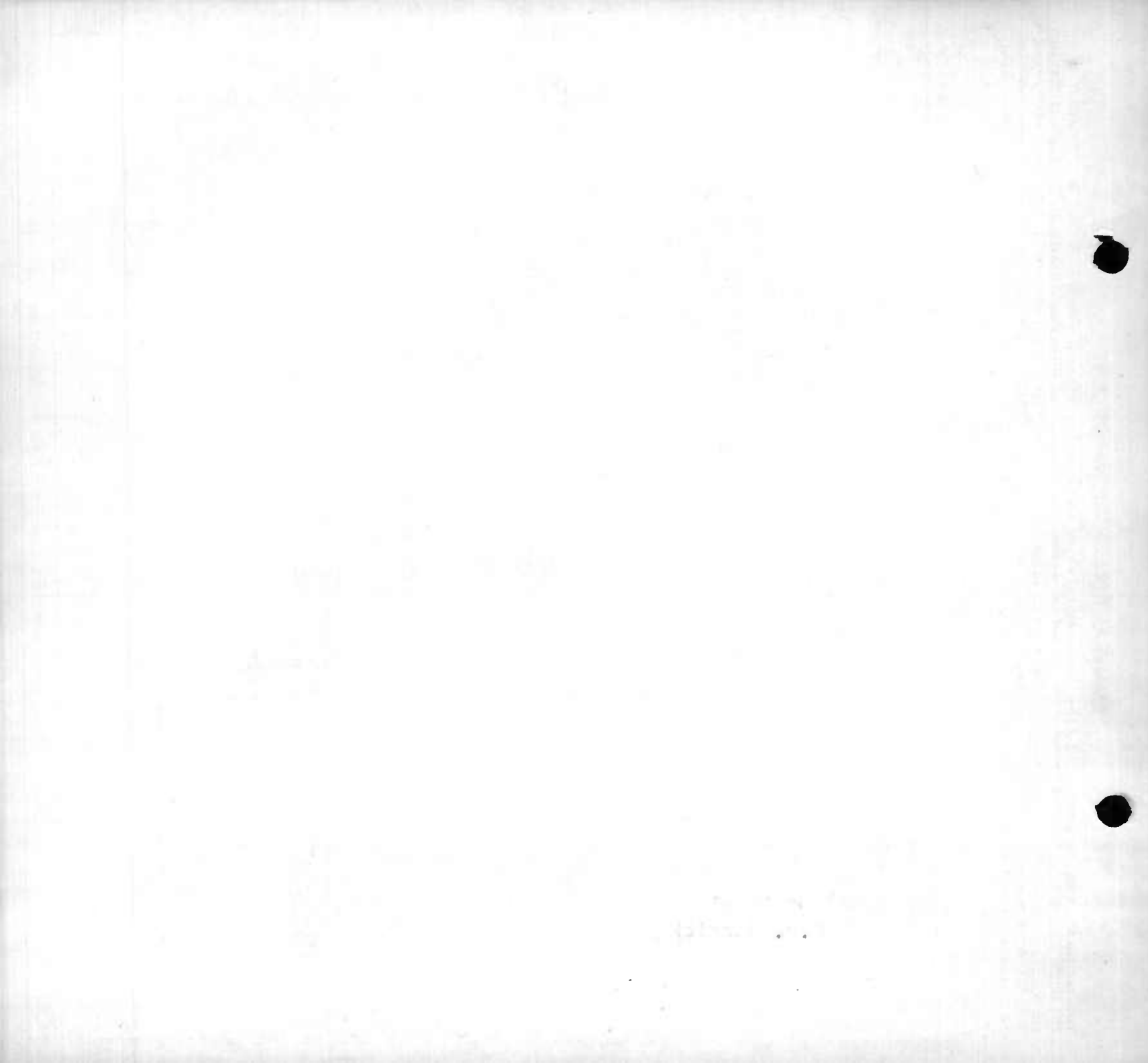
BIRTH NO. 65 3610				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3610	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>SHIPLEY, CLARENCE</b>				2. DATE AND HOUR OF DEATH <b>April 3, 1965 6:40 A.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. JOSEPH HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>27-14</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>119 Hawthorne Road</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Widowed</b>	8. DATE OF BIRTH <b>2/21/98</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Blanchard Press</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unk</b>			14. MOTHER'S MAIDEN NAME <b>Unk</b>			17. INFORMANT <b>Ronald Shipley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>213-058859</b>		ADDRESS <b>119 Hawthorne Rd</b>		
18. <b>157X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of pancreas with metastases.</b>				CAUSE OF DEATH (A) <b>Carcinoma of pancreas with metastases.</b> (B) <b>Due to</b> (C) <b></b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 12, 1965</b> to <b>April 3, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Javad Towfighi</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 3, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Javad Towfighi,</b>				23D. ADDRESS M.D. <b>1400 N. Caroline St., Baltimore, Md. 21213</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>R. E. Estabrook</b>		25C. FUNERAL DIRECTOR <b>Paul E. Estabrook</b>		ADDRESS <b>13615</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 3611</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 3611</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.			2. DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">EARL WALDO CAMPBELL</span>			1 APRIL 1965   4:00 A. M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">UNIVERSITY HOSPITAL</span>			A. STATE <span style="font-size: 1.2em;">MARYLAND</span>		
			B. COUNTY <span style="font-size: 1.2em;">15-48</span>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township)		
			<span style="font-size: 1.2em;">BALTIMORE</span>		
			D. STREET ADDRESS (If rural, give location)		
			<span style="font-size: 1.2em;">3516 CLIFTON AVENUE</span>		
5. SEX <span style="font-size: 1.2em;">MALE</span>	6. RACE <span style="font-size: 1.2em;">NEGRO</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">12/13/06</span>	9. AGE (In years lost birthday) <span style="font-size: 1.2em;">58</span>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">MAIL HANDLER</span>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">WILLIAM CAMPBELL</span>			14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">SUSIE THORNTON</span>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">YES WWI</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">212-10-4097</span>	17. INFORMANT <span style="font-size: 1.2em;">Eline K. Campbell</span>		ADDRESS <span style="font-size: 1.2em;">Same</span>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <span style="font-size: 1.2em;">GASTROINTESTINAL</span> DUE TO <span style="font-size: 1.2em;">HAEEMORRAGE</span> (B) <span style="font-size: 1.2em;">GASTROINTESTINAL VASCLES</span> DUE TO (C) <span style="font-size: 1.2em;">HAEEMORRAGE'S CIRCULOSIS</span>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">18 MARCH</span> 1965 to <span style="font-size: 1.2em;">1 APRIL</span> 1965, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1 APRIL</span> 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">D.M. Barrick</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">4/1/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">D.M. Barrick</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">UNIVERSITY HOSPITAL - BALTIMORE</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4-6-65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">Baltimore National</span>	
24D. LOCATION <span style="font-size: 1.2em;">Baltimore MD.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 6 1965</span>			
25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. [unclear]</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Wilmington &amp; Phillips 1727 N. Monroe St.</span>			





65 3612 BALTIMORE CITY HEALTH DEPARTMENT 65 3612

M 622

BIRTH NO. \_\_\_\_\_ M.E. CASE NO. \_\_\_\_\_

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
DAVID MARCUS <i>Sc.</i>		April 1, 1965 10:35 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
Provident Hospital		Maryland	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)	
		Baltimore	
		D. STREET ADDRESS (If rural, give location)	
		3108 Reisterstown Road	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH
Male	Negro		Sept. 9, 1932
9. AGE (In years last birthday)	10. BIRTHPLACE (State or foreign country)		11. CITIZEN OF WHAT COUNTRY?
32	Lamar, South Carolina		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
Laborer		Construction	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Marcus		Ophelia Kirkland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		249-46-7539	
17. INFORMANT		ADDRESS	
Ernestine Marcus		Same	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  Cerebral Injury (contusions of brain and thrombosis of left middle cerebral artery with encephalomalacia.)			
II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		Yes	Yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
	Street	Reisterstown Rd., S. of Liberty Hgts.	
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)	WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	Driver of auto into fixed object.	
3	20 '65 A		
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Charles S. Petty, M.D.		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
23A. BURIAL CREMATION, REMOVAL (Specify)	23B. DATE	23C. NAME OF CEMETERY or CREMATORY	23D. LOCATION (City, town, or county) (State)
Removal	4-5-65	Bethel	Lamar S. C.
24A. DATE REC'D BY HEALTH DEPT.	24B. NAME OF REGISTRAR	24C. FUNERAL DIRECTOR ADDRESS	
APR 6 1965	Robert E. Taylor, M.D.	Arlington Phillips 17 27th Monmouth	

VS 151-REV. 1/1/65

VALLEY POLICE

REPORT

DATE

TIME

PLACE

NAME

ADDRESS

CITY

STATE

ZIP

TELEPHONE

AGE

SEX

RACE

HEIGHT

WEIGHT

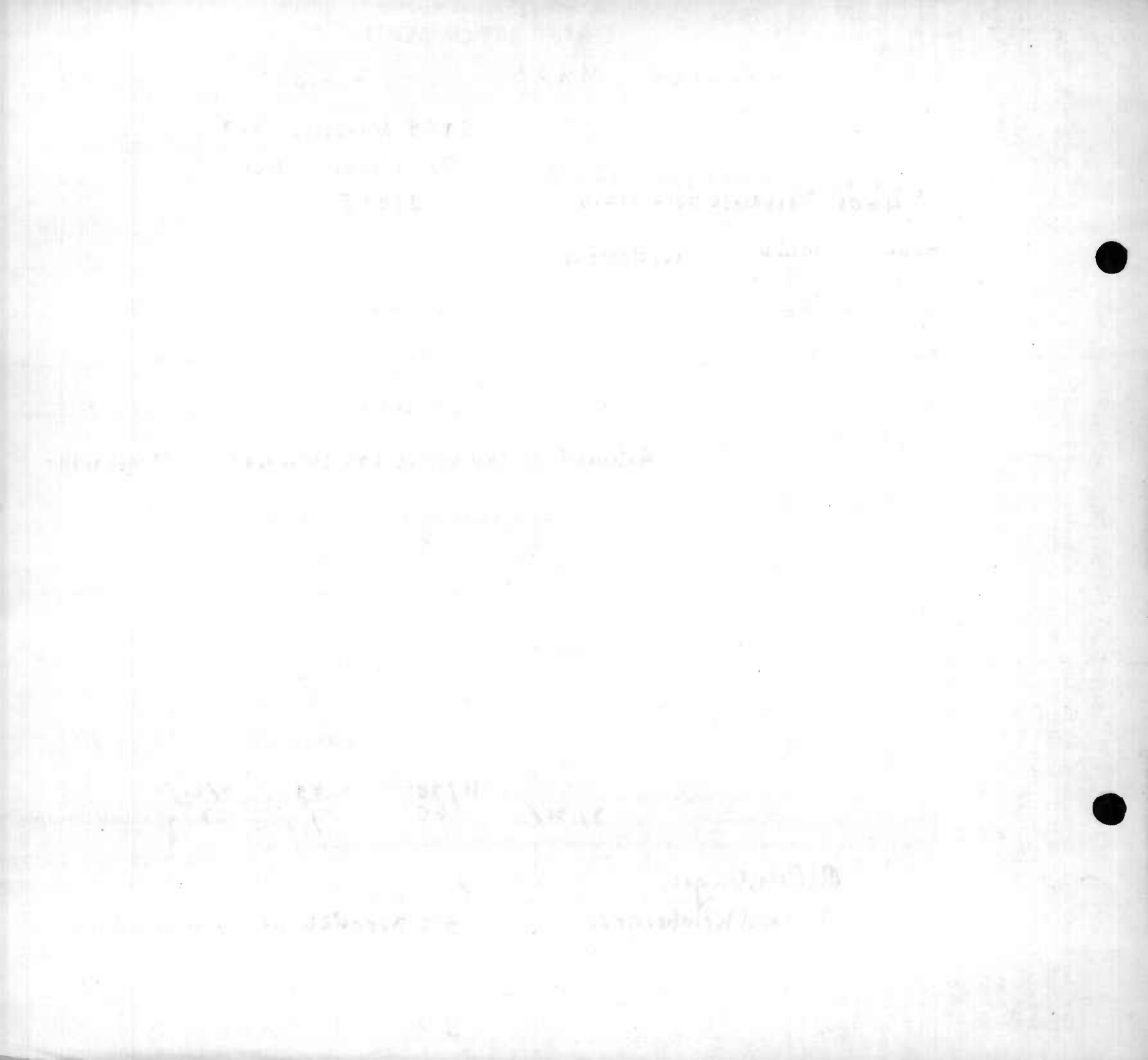
HAIR

EYES

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

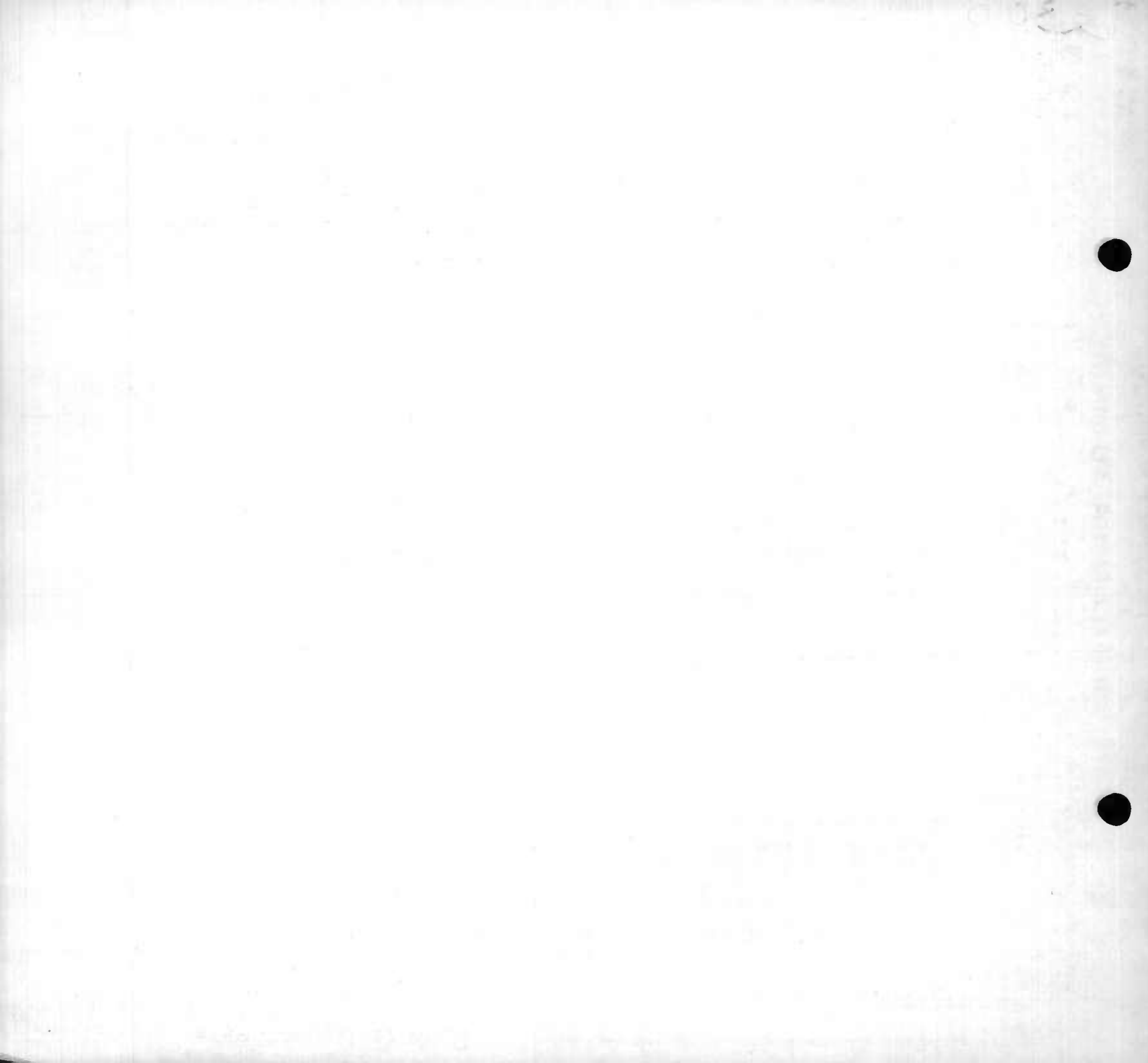
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 3613					CERTIFICATE OF DEATH			Registered No. 65 3613	
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) CAROLINE MAAS					2. DATE AND HOUR OF DEATH 4-1-65 1245 P. M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)			A. STATE		B. COUNTY		
Jewish Convalescence HOME		4601 Fairmount Rd - 21215			5709 NARCISSE AVE		27-19		
C. CITY OR TOWN (If outside city limits, write RURAL and give township)					D. STREET ADDRESS (If rural, give location)				
Baltimore, MD					21215				
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
Female	White	Widowed		7-11-1875	89				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE						GERMANY		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
JACOB MEYBERG					SIMETTE SCHONEMANN				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				No		ELSE MAAS. 5709 NARCISSE AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					CAUSE OF DEATH				
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)					(A) DUE TO				
ANTECEDENT CAUSES					(B) DUE TO				
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					No				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?				
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from 11/30 1965 to 3/31/ 1965, that (I) (we) last saw the deceased alive on 3/31/ 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE					M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED	
Richard Weinberger									
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS				
Richard Weinberger					912 Brooks Lane, Baltimore, Md. 21217				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
BURIAL		4-4-65		CHERRY HAVEN CHESED		PANDALLSTOWN MD			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
APR 6 1965		Robert E. Weinberger		Jacob Reuter		3100 East...			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Detained was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 3614					CERTIFICATE OF DEATH					Registered No. 65 3614				
1. NAME OF DECEASED (Type or Print) BESSIE QUITT					2. DATE AND HOUR OF DEATH 3/31/65 11:20 AM M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 THE JOHNS HOPKINS HOSPITAL					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 15-12					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
D. STREET ADDRESS (If rural, give location) 2810 VIOLET AVENUE					5. SEX FEMALE					6. RACE WHITE				
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE					8. DATE OF BIRTH 1-1-92					9. AGE (In years last birthday) 73				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY CLOTHING					11. BIRTHPLACE (State or foreign country) RUSSIA					12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME LOUIS QUITT					14. MOTHER'S MAIDEN NAME EVA					15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 215-03-6671					17. INFORMANT SON QUITT					ADDRESS 901 LAKE DRIVE BALTIMORE MD				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ADENOCARCINOMA OF STOMACH (Linitis Plastica)					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO					INTERVAL BETWEEN ONSET AND DEATH 1 year				
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 2/15 1965 to 3/31 1965, that (I) (we) last saw the deceased alive on 3/30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE Carl E. Bredenberg										23B. DATE/SIGNED 3/31/65				
23C. PHYSICIAN'S NAME (Type) CARL E. BREDEBERG										23D. ADDRESS JOHNS HOPKINS HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE 4-4-65					24C. NAME of CEMETERY or CREMATORY ROSEDALE				
24D. LOCATION (City, town, or county) (State) BALTIMORE MD					25A. DATE REC'D BY HEALTH DEPT. APR 6 1965					25B. NAME OF REGISTRAR Robert E. Stankard				
25C. FUNERAL DIRECTOR Jack Lewis Inc					25D. ADDRESS 2100 East Ave									

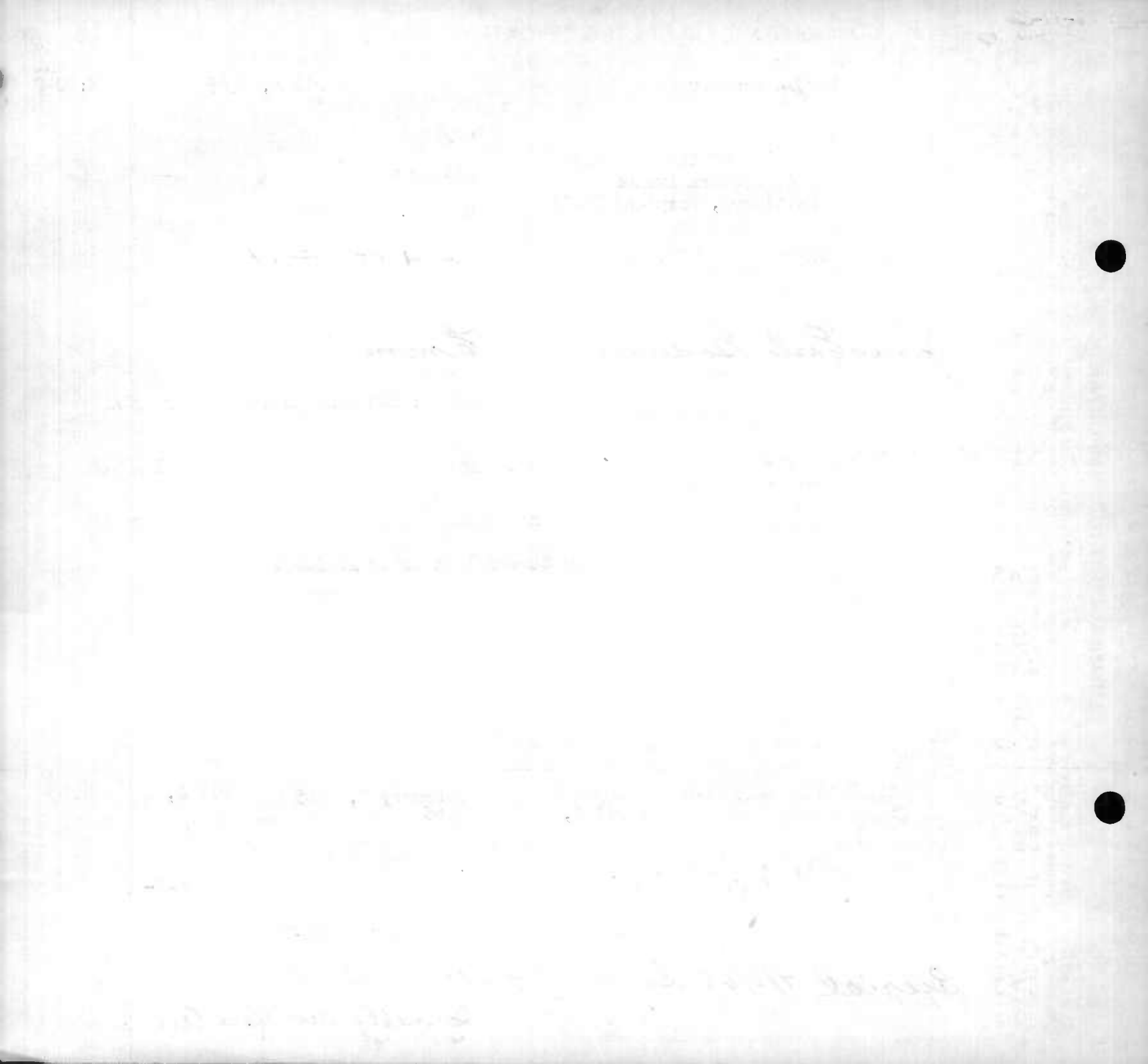


Reg: 42-77-32

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 3615</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3615</b>	
M.E. CASE NO.			DATE AND HOUR OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Marian Deshner</b>			<b>April 4, 1965 8:00 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>			A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		
5. SEX <b>Female</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
6. RACE <b>White</b>			D. STREET ADDRESS (If rural, give location) <b>6306 Toone Street</b>		
7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widowed</b>			9. AGE (In years last birthday) <b>65 64</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		
10B. KIND OF BUSINESS OR INDUSTRY			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James Earl Godwin</b>			14. MOTHER'S MAIDEN NAME <b>Emm</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT			ADDRESS		
			<b>RECORDS: BCH 4940 Eastern Avenue #24</b>		
18. <b>331X I</b>			CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) <b>Septicemia</b> DUE TO		
ANTECEDENT CAUSES			(B) <b>Pneumonia</b> DUE TO		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C) <b>Cerebral Vascular Accident</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <b>Yes</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>February 7, 19 65</b> to <b>April 4, 19 65</b> , that (I) (we) lost saw the deceased alive on <b>April 4, 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Philip Zieve</b>			23B. DATE SIGNED <b>4-4-65</b>		
23C. PHYSICIAN'S NAME (Type) <b>Philip Zieve</b>			23D. ADDRESS <b>4940 Eastern Avenue 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>4/7/65</b>		
24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith</b>			24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>			25B. NAME OF REGISTRAR <b>G. E. Taylor</b>		
25C. FUNERAL DIRECTOR <b>Connelly</b>			ADDRESS <b>300 Maple Ave. Balto. 21</b>		

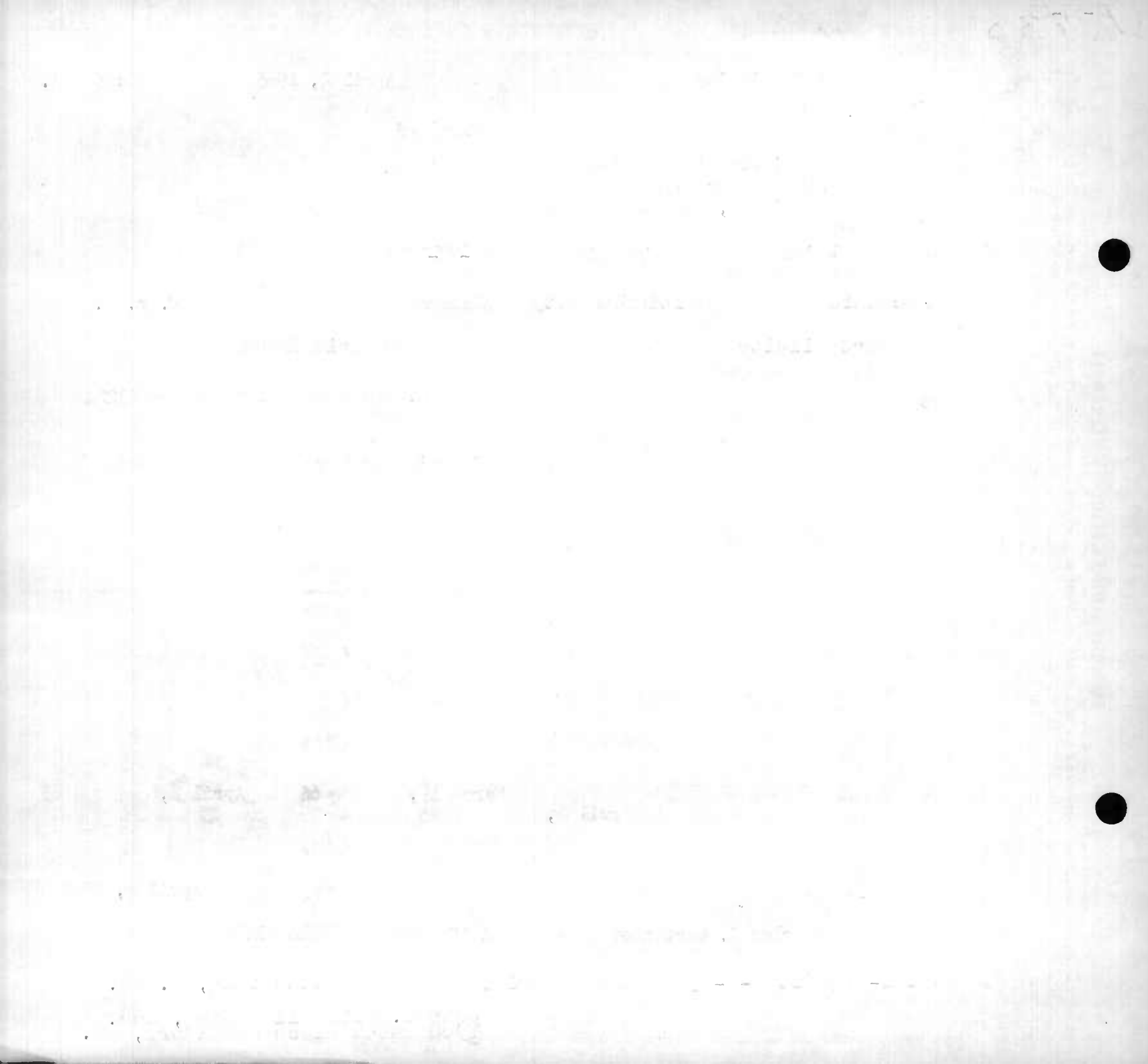




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

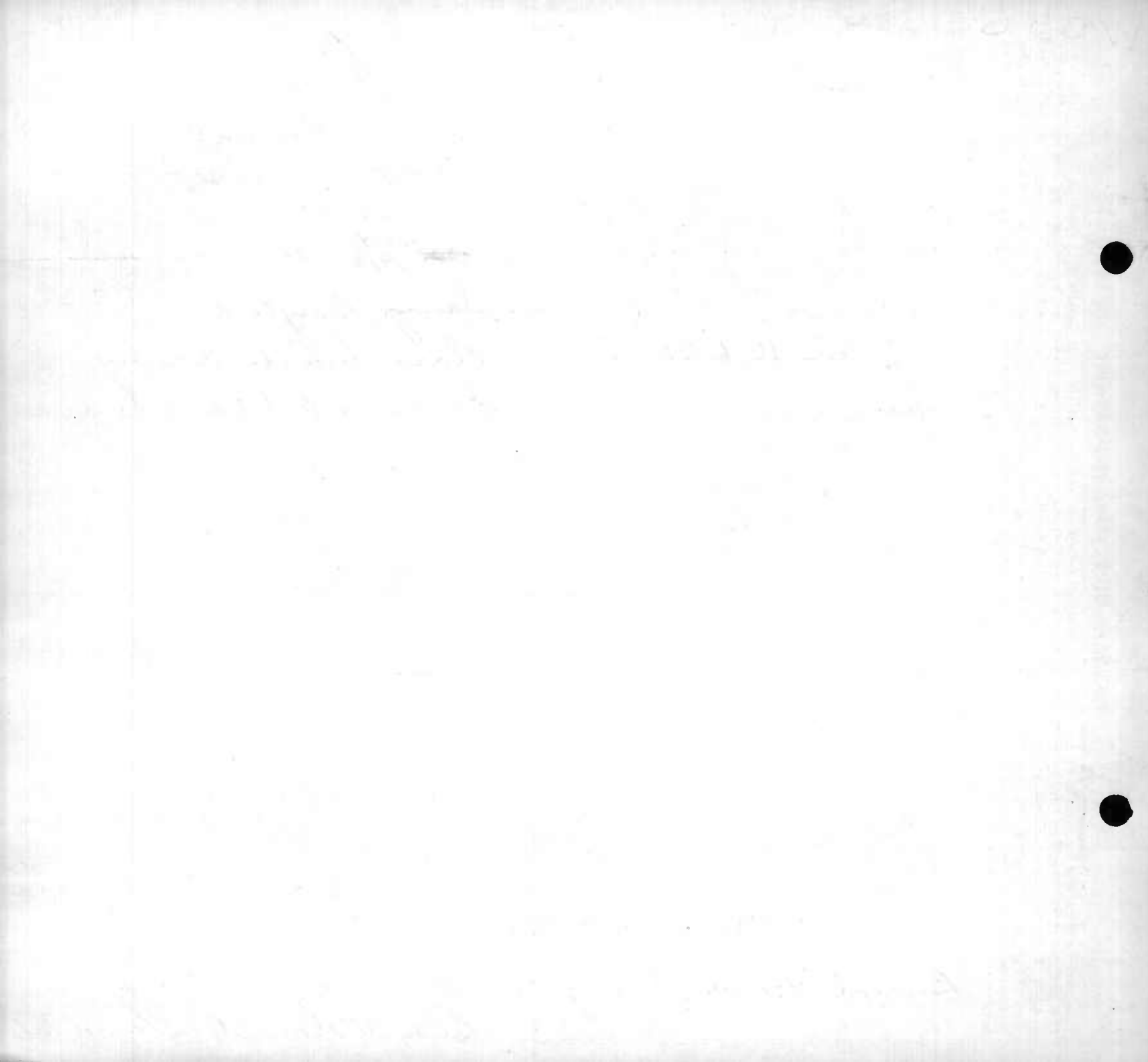
BALTIMORE CITY HEALTH DEPARTMENT				Certificate of Death		Registered No. 65 3616	
BIRTH NO. 65 3616		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Russell Wilhite		2. DATE AND HOUR OF DEATH April 2, 1965   11:55 A. M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		(If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY 26-05	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
				D. STREET ADDRESS (If rural, give location) 401 Anglesea Street 21224			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Divorced		8. DATE OF BIRTH 11-27-1913	9. AGE (In years last birthday) 51	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10B. KIND OF BUSINESS OR INDUSTRY Baltimore City		11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bert Wilhite				14. MOTHER'S MAIDEN NAME Charlsie Mason			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) Bronchiogenic Carcinoma DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 Years	
19. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from March 19, 19 64 to April 2, 19 65, that (I) (we) last saw the deceased alive on April 2, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Charles C. Carpenter</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 2, 1965	
23C. PHYSICIAN'S NAME (Type) Charles C. Carpenter				23D. ADDRESS M.D. 4940 Eastern Avenue 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial-Transit 4-2-65		24B. DATE APR 6 1965		24C. NAME of CEMETERY or CREMATORY Huse Memorial		24D. LOCATION (City, town, or county) (State) Fayetteville, W. Va.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR John O. Mitchell & Sons, Inc. 1900 Eutan Place Baltimore, Md.		ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

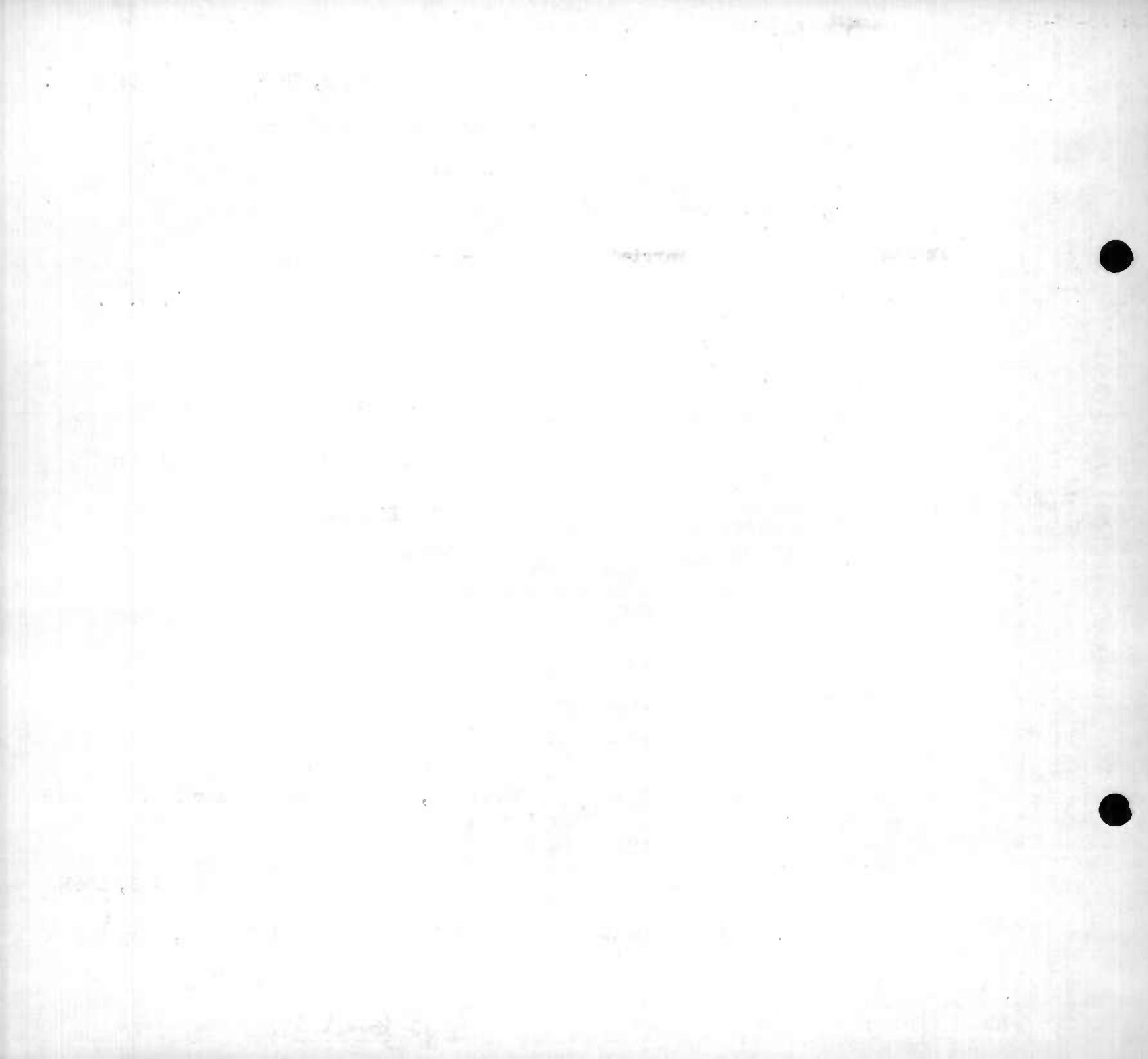
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <b>65653617</b>		<b>CERTIFICATE OF DEATH</b>				Registered No. <b>65 3617</b>			
M.E. CASE NO. <b>1. NAME OF DECEASED</b> <i>EARVIN J. Whitehead</i>						2. DATE AND HOUR OF DEATH <i>March 28, 1965 11:20 P. M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>HOWARD</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>UNIVERSITY HOSPITAL</i>						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Savage 63-00</i>			
						D. STREET ADDRESS (If rural, give location) <i>RFD Box 44</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Never Married</i>		8. DATE OF BIRTH <i>Dec 14, 1912</i>	9. AGE (In years last birthday) <i>52</i>	If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cabaret</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>US Gent Farm</i>		11. BIRTHPLACE (State or foreign country) <i>Savage Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Julius Whitehead</i>				14. MOTHER'S MAIDEN NAME <i>Clara Lucinda Wasker</i>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>yes</i>				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <i>Lawrence Whitehead Savage Md</i>			
<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>18. <i>420.11</i></p> <p><b>CAUSE OF DEATH</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p>(A) <i>Acute myocardial infarction</i></p> <p>DUE TO</p> <p>(B) DUE TO</p> <p>(C) DUE TO</p> </div> </div>									
<p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>									
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?				
<p>22. I certify that (I) (this hospital) attended the deceased from <i>3/28</i> 19 <i>65</i> to <i>3/28</i> 19<i>65</i>, that (I) (we) last saw the deceased alive on <i>3/28</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>									
23A. SIGNATURE <i>Franklin M. Preiser</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <i>3/28/65</i>			
23C. PHYSICIAN'S NAME (Type) <i>Franklin M. Preiser</i> M.D.						23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-1-65</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Savage Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Savage, Maryland</i>			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 6 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Selby M.D.</i>		25C. FUNERAL DIRECTOR ADDRESS <i>Edna J. Selby, 2135 Landon Rd, Md.</i>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3618</b>	
BIRTH NO. <b>65 3618</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>(Amalia) Amelia Lewandowski</b>		<b>April 3, 1965</b>   <b>5:50 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>RURAL: Rosedale</b> <b>53-00</b>	
		D. STREET ADDRESS (If rural, give location) <b>7906 Roseland Avenue #21206</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>10-16-10</b>
		9. AGE (In years lost birthday) <b>54</b>	10. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Indiana</b>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Joseph Ostrowski</b>		14. MOTHER'S MAIDEN NAME <b>Anna Gardyza</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
		17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue</b>	
18. <b>201X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hodgkins Disease</b>		<b>1 Year</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 22, 1965</b> to <b>April 3, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Dr. Charles Carpenter</b>		23B. DATE SIGNED <b>April 3, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Charles Carpenter</b>		23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>April 7, '65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Holy Rosary Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>	25B. NAME OF REGISTRAR <b>Regis. Sec'y</b>	25C. FUNERAL DIRECTOR ADDRESS <b>1211 Chesaco Avenue 21206</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3619				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3619	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
				SHEPARD MORSE. Z		4/4/65 12:30 AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
Lutheran Hosp.				A. STATE Maryland.		2803	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
46				Baltimore. 7 Md.			
				D. STREET ADDRESS (If rural, give location)			
				5000 WETHERSVILLE. RD			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months	If Under 24 Hrs. Days	If Under 24 Hrs. Hours
Female	white	WIDOWED, DIVORCED (specify)	11/14/85	80 years			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
unemployed.		none		Virginia		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Zeigler				Julia Hancock			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Harold W. Payne		506 Lloyd Lane Alex., V	
18. CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				Cerebral vascular accident. sudden ly.			
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO			
ANTECEDENT CAUSES				(B) DUE TO Hypertension.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				No			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
		none		none			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
none		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		none			
22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) last saw the deceased alive on 4/3 @ 4 PM 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Rafae						4/4/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Dr Leon ASHMAN.							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		4/7/65		Mount Comfort		Fairfax Co. Virginia	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 6 1965		Robert E. Hubbard		HOWARD H. HUBBARD		4107 WILKENS AVE. 21229	

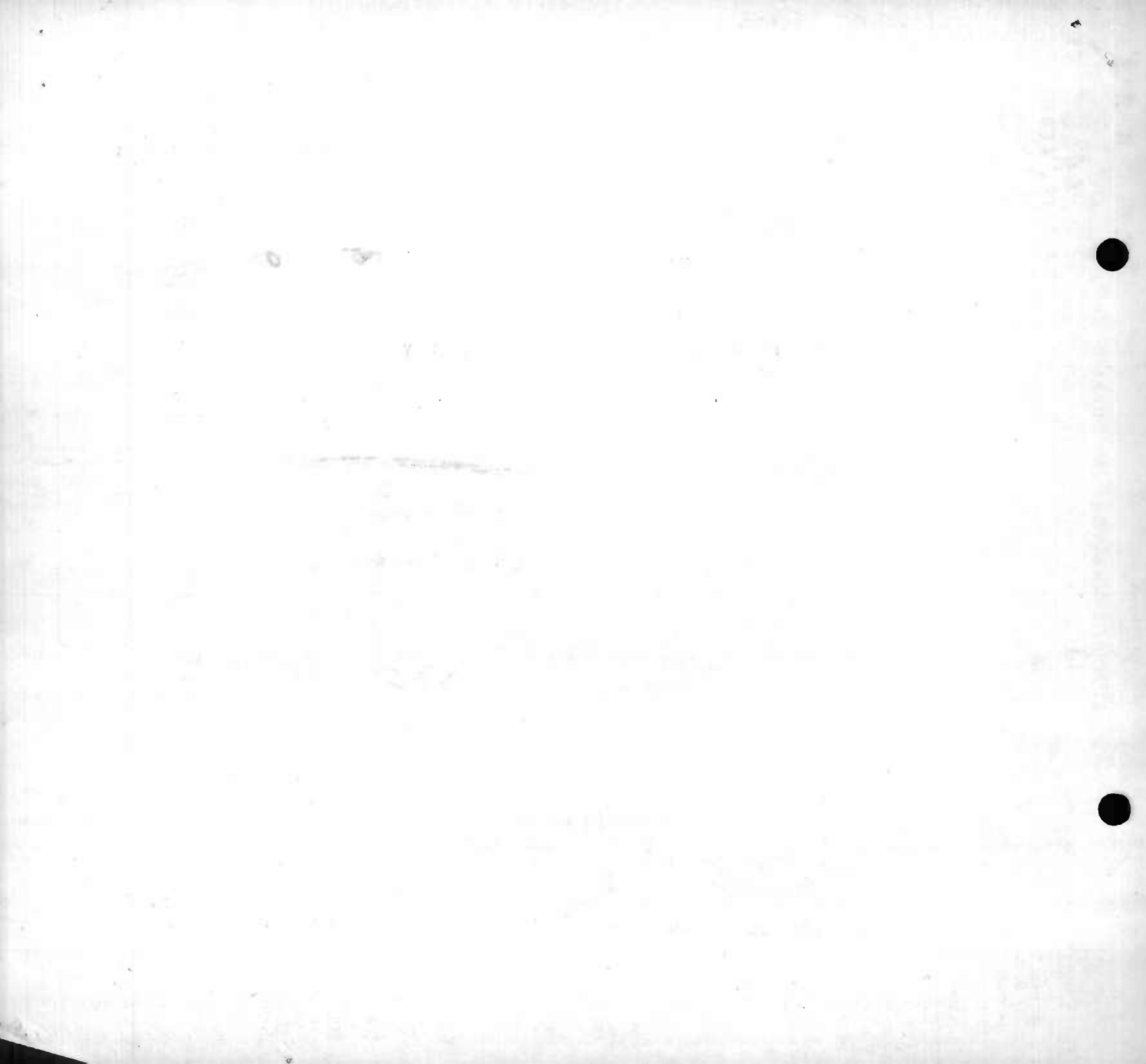




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT															
BIRTH NO. 685 3620					CERTIFICATE OF DEATH					Registered No. 65 3620					
M.E. CASE NO.					2. DATE AND HOUR OF DEATH										
1. NAME OF DECEASED (Type or Print) <u>Lloyd Croner</u>					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)										
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore Co.</u>										
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township)										
<u>The Johns Hopkins Hospital</u>					D. STREET ADDRESS (If rural, give location)										
					<u>417 E. Pennsylvania Ave.</u>										
5. SEX <u>M</u>		6. RACE <u>C</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>married</u>		8. DATE OF BIRTH <u>03-15-05</u>		9. AGE (in years, last birthday) <u>60</u>		If Under 1 Yr. Months: Days: Hours: Min.					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
<u>Laborer</u>				<u>contractors</u>				<u>Pa.</u>				<u>U.S.A</u>			
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME										
<u>HENNISON CRONER</u>					<u>BETTY. ?</u>										
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS					
<u>no</u>					<u>220-05-7290</u>					<u>Dorothy Croner - 417 E. Pa. ave. Towson Md</u>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH					
ANTECEDENT CAUSES					(A) DUE TO <u>BRONCHIAL OBSTRUCTION</u>					<u>2 year</u>					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(B) DUE TO <u>ASPIRATION</u>										
					(C) <u>CARCINOMA OF Lung</u>										
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.															
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
<u>2</u>						<u>YES</u>									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.)			21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?									
			While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>												
22. I certify that (a) (This hospital) attended the deceased from <u>3/23</u> 19 <u>65</u> to <u>4/2</u> 19 <u>65</u> , that (b) (we) last saw the deceased alive on <u>4/2</u> 19 <u>65</u> and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (d) (We) (did) (did not) view the body after death.															
23A. SIGNATURE <u>Michael Lesch</u>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>					23B. DATE SIGNED <u>4/2/65</u>					
23C. PHYSICIAN'S NAME (Type) <u>MICHAEL LESCH</u>					M.D. 23D. ADDRESS										
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY			24D. LOCATION (City, town, or county) (State)								
<u>Burial</u>		<u>4/7/65</u>		<u>Pleasant Rest</u>			<u>Towson, Balto. Co. Md.</u>								
25A. DATE REC'D BY HEALTH DEPT			25B. NAME OF REGISTRAR			25C. FUNERAL DIRECTOR			ADDRESS						
<u>APR 6 1965</u>			<u>Robert E. Galt</u>			<u>John H. Robertson, Jr. 1701 McCulloch</u>			<u>Balto. Md.</u>						



BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

ERNEST L. CADE

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965

2:30 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

514 E. Eager St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

MARRIED - SEPARATED

8. DATE OF BIRTH

5-15-1923

9. AGE (In years last birthday)

40-42

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

CORA HICKS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

YES

WAR 2

16. SOCIAL SECURITY NO.

241-24-2250

17. INFORMANT

ADDRESS

LILLIE-WALKER 1522 N. BROADWAY

18.

330X

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Massive subarachnoid hemorrhage DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) Ruptured cerebral aneurysm DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4-3-65

23A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

23B. DATE

4-8-65

23C. NAME OF CEMETERY or CREMATORY

BALTIMORE NATIONAL

23D. LOCATION (City, town, or county) (State)

BALTIMORE MD

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Fisher

24C. FUNERAL DIRECTOR

JOSEPH KNIGHT 1639 N. BROADWAY

ADDRESS

WALLEN BOITGE

HEAD CONTENT

1-2-1

1-2-1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

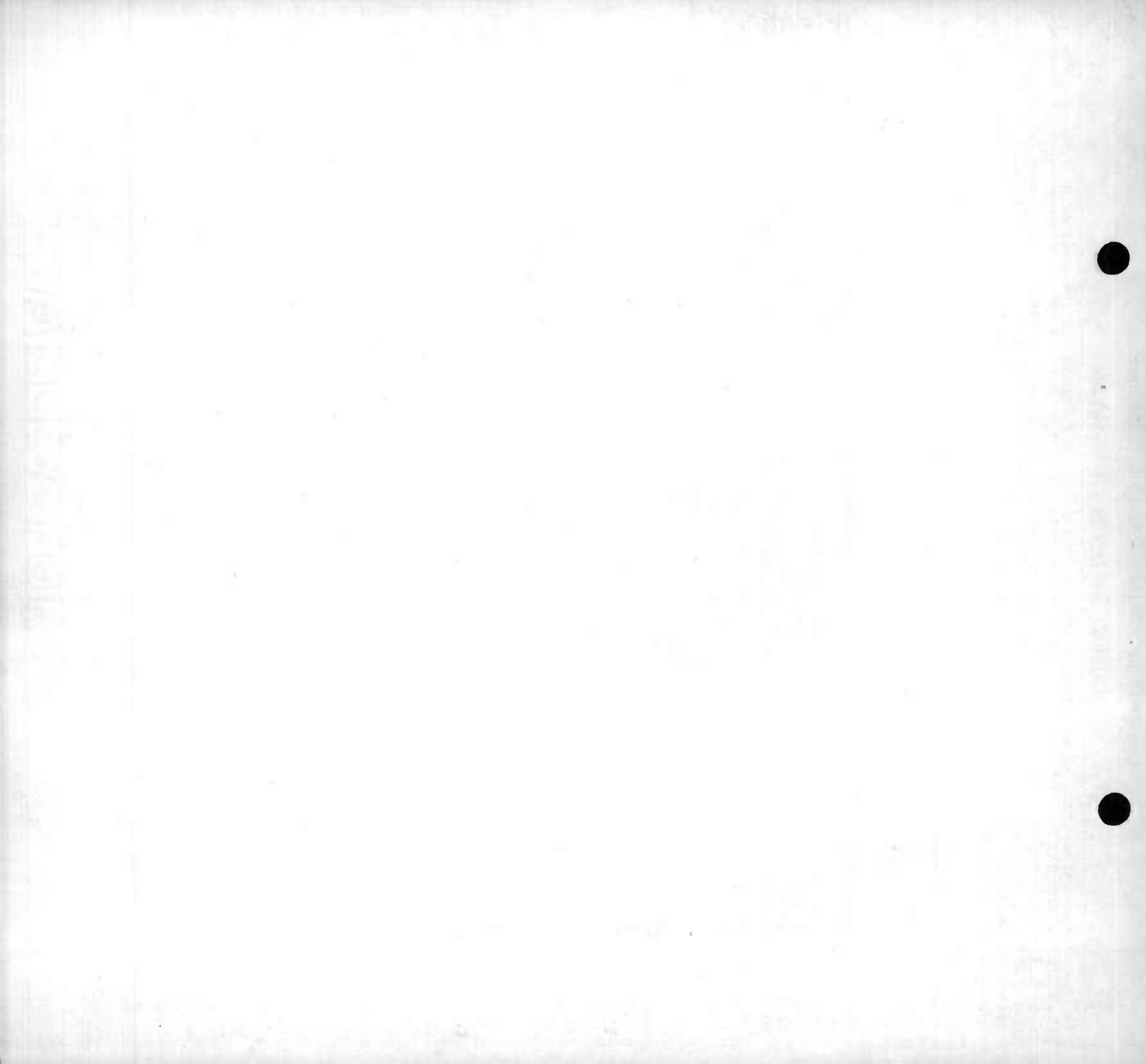
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		Registered No. <span style="font-size: 1.2em;">65 3622</span>	
BIRTH NO. <span style="font-size: 1.2em;">665 3622</span>		M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">HARRIS, HERMAN</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">APR. 5 1965</span> <span style="font-size: 1.2em;">7<sup>30</sup> A.M.</span>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">33 JOHNS HOPKINS HOSPITAL</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">12 7-10</span>			
5. SEX <span style="font-size: 1.2em;">MALE</span>		6. RACE <span style="font-size: 1.2em;">NEGRO</span>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">MARRIED</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">4-8-16</span>	
9. AGE (In years last birthday) <span style="font-size: 1.2em;">48</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">LABORER</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">EASTERN STAIR CO.</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">HERMAN, HARRIS</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">LENA PAGE</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>	
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">21707-0257</span>		17. INFORMANT <span style="font-size: 1.2em;">LENELL HARRIS</span>		ADDRESS <span style="font-size: 1.2em;">4417 ST. GEORGE AVE.</span>		18. CAUSE OF DEATH <span style="font-size: 1.2em;">443X I</span>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <span style="font-size: 1.2em;">HEMORRHAGE</span> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">2 DAYS</span>		(B) <span style="font-size: 1.2em;">UREMIA</span> DUE TO	
(C) <span style="font-size: 1.2em;">HYPERTENSIVE ARTERIOSCLEROTIC DISEASE</span>		<span style="font-size: 1.2em;">20 YRS.</span>					
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">Yes</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">APR. 3</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">APR. 5</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">APR. 5</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.2em;">Paul D. Hart</span>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <span style="font-size: 1.2em;">4-5-65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">PAUL D. HART</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">JOHNS HOPKINS HOSP., BALTO. 5, MD.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">4-9-65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">CARVER-MEMORIAL PARK</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">LAUREL Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 6 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robt E. Taylor</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">JOSEPH KNIGHT</span>		ADDRESS <span style="font-size: 1.2em;">1639 N. BROADWAY</span>	

2

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 665 3623				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3623	
1. NAME OF DECEASED (Type or Print) <b>TYRONE WALTON</b>				2. DATE AND HOUR OF DEATH <b>4-2-'65</b>   <b>5:35 pm</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>ON WAY TO JOHN'S HOPKINS HOSPITAL FROM HOME</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b>			
5. SEX <b>M</b> 6. RACE <b>N</b> 7. <del>MARRIED, NEVER MARRIED</del> <b>WIDOWED, DIVORCED</b> (Specify)				8. DATE OF BIRTH <b>9-27-63</b>		9. AGE (In years last birthday) <b>21 1/2</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>				10B. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>ROBERT WALTON</b>			
14. MOTHER'S MAIDEN NAME <b>JULIA CARTER</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			
16. SOCIAL SECURITY NO. —				17. INFORMANT <b>Mother</b> ADDRESS <b>SAME</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 minute</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Probable aspirin</b>				8 hours.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4-2-1965</b> to <b>4-2-1965</b> , that (I) (we) last saw the deceased alive on <b>(Dead on arrival)</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(We)</b> (did) (did not) view the body after death.							
23A. SIGNATURE <b>Priscilla A. Gilman</b>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-2-'65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Priscilla A. Gilman</b>				23D. ADDRESS <b>BALTIMORE 5 MD. JOHN'S HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4-7-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. COUNTY Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Joseph E. Stedman</b>		25C. FUNERAL DIRECTOR ADDRESS <b>JOSEPH KNIGHT 1639 N. BROADWAY</b>			

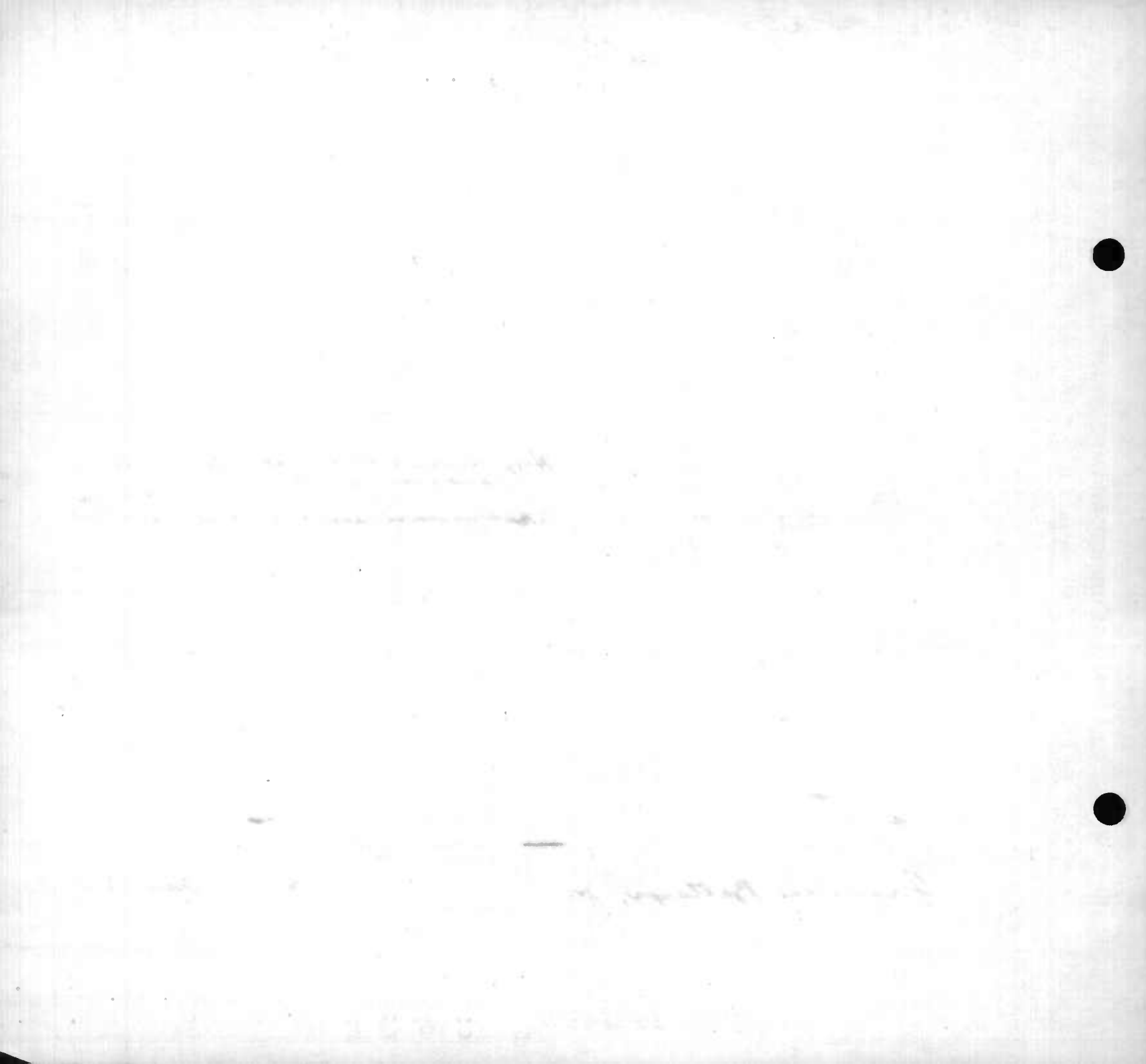




# FUNERAL DIRECTOR: IMPORTANT

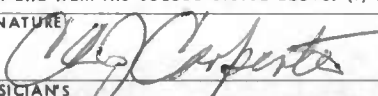
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

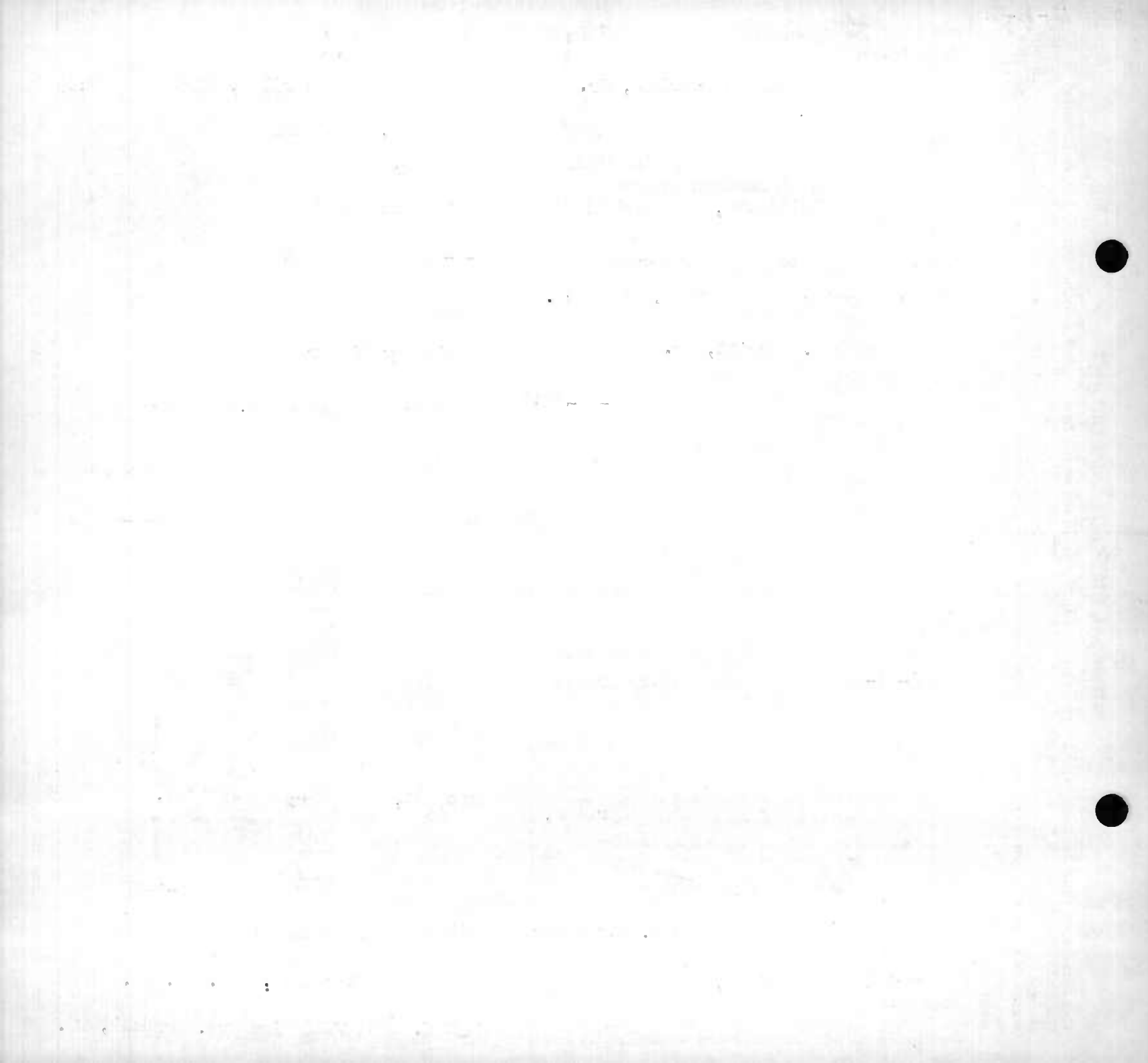
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. <span style="font-size: 1.2em;">65 3624</span>				
BIRTH NO. <span style="font-size: 1.2em;">65 3624</span>					M.E. CASE NO. <span style="font-size: 1.2em;">65 3624</span>				
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Elizabeth Quinn</span> <span style="font-size: 1.2em;">Sister MARY Gilberta, O.P.</span>					2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">4-4-65</span> <span style="font-size: 1.2em;">5 05 P.M.</span>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">Bm Secours Hosp</span> <span style="font-size: 1.2em;">2025 West Fayette</span>					A. STATE <span style="font-size: 1.2em;">Md.</span>				
					B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>				
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>					D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">720 Maiden Lane</span> <span style="font-size: 1.2em;">Baltimore Md. 28</span> <span style="font-size: 1.2em;">5300</span>				
					E. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore</span>				
5. SEX <span style="font-size: 1.2em;">Female</span>		6. RACE <span style="font-size: 1.2em;">White</span>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">single</span>		8. DATE OF BIRTH <span style="font-size: 1.2em;">Aug 13, 1887</span>		9. AGE (In years last birthday) <span style="font-size: 1.2em;">77 yrs</span>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Religious Sister</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Religious</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">New Jersey</span>		12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			
13. FATHER'S NAME <span style="font-size: 1.2em;">John Quinn</span>					14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Mary Quinn</span>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>					16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">no</span>		17. INFORMANT <span style="font-size: 1.2em;">Mother Mary Devine Heart</span>		
					ADDRESS <span style="font-size: 1.2em;">720 Maiden</span>				
18. <span style="font-size: 1.2em;">443X I</span>					CAUSE OF DEATH				
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					A) <span style="font-size: 1.2em;">Hypertensive Arteriosclerosis</span> DUE TO <span style="font-size: 1.2em;">Cardiovascular Disease</span>				
					B) <span style="font-size: 1.2em;">Cerebrovascular accident</span> DUE TO <span style="font-size: 1.2em;">Days</span>				
					C) _____				
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-31</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">4-4</span> 19 <span style="font-size: 1.2em;">65</span> , that (we) lost saw the deceased alive on <span style="font-size: 1.2em;">4-4-65</span> 19 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) view the body after death.									
23A. SIGNATURE <span style="font-size: 1.2em;">Francisco Ballagan, Jr.</span>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <span style="font-size: 1.2em;">April 4, 1965</span>	
23C. PHYSICIAN'S NAME (Type)					23D. ADDRESS M.D.				
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)			
<span style="font-size: 1.2em;">Burial</span>		<span style="font-size: 1.2em;">April 6, 1965</span>		<span style="font-size: 1.2em;">Domonican Sisters Cemetery</span>		<span style="font-size: 1.2em;">720 Maiden Choice b Catonsville, Md.</span>			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS					
<span style="font-size: 1.2em;">APR 6 1965</span>		<span style="font-size: 1.2em;">Robert E. [unclear]</span>		<span style="font-size: 1.2em;">Sterling Funeral Estate 736 Edm. Av.</span>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 3625		CERTIFICATE OF DEATH		Registered No. 65 3625	
1. NAME OF DECEASED (Type or Print) <b>Enoch Merritt, Jr.</b>						2. DATE AND HOUR OF DEATH <b>April 4, 1965 7:45 P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland, Baltimore</b> B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Edgemere 53-00</b> D. STREET ADDRESS (If rural, give location) <b>3112 Lynch Road</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>Divorced</b>		8. DATE OF BIRTH <b>8-2-06</b>		9. AGE (In years last birthday) <b>58</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shear Operator</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Enoch W. Merritt, Sr.</b>						14. MOTHER'S MAIDEN NAME <b>Addie May Fisher</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-01-4546</b>		17. INFORMANT <b>RECORDS: BCH 4940 Eastern Avenue</b>			
18. <b>493 X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.						CAUSE OF DEATH (A) <b>Meningitis</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
						(B) <b>Pneumonia</b> DUE TO		<b>1-2-weeks</b>	
						(C) _____			
19A. DATE OF OPERATION <b>3-31-64</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Respiratory Arrest</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>March 31, 1965</b> to <b>April 4, 1965</b> , that (I) (we) lost saw the deceased alive on <b>April 4, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE  M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>						23B. DATE SIGNED <b>4-4-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Charles C. Carpenter M.D.</b>						23D. ADDRESS <b>4940 Eastern Avenue 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>April 7, 1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Eastern Ave. Bal. Co. Md. 21222</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>JOHN A. DUDA</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md. 22</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 3626		CERTIFICATE OF DEATH		Registered No. 65 3626	
1. NAME OF DECEASED (Type or Print) <b>Charlotte M. Gorsuch.</b>				2. DATE AND HOUR OF DEATH <b>April 3, 1965 7 A. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>839 Wellington St.</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1306</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>839 Wellington St.</b>					
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>		8. DATE OF BIRTH <b>May 10, 1878</b>		9. AGE (in years lost birthday) <b>86</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>Asbury Phillips.</b>				14. MOTHER'S MAIDEN NAME <b>Almira Shipley.</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Miss. Thelma Gorsuch, 839 Wellington St</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b> <b>Coronary Thrombosis</b>				CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Chronic myocarditis</b>		INTERVAL BETWEEN ONSET AND DEATH <b> sudden</b> <b> years</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (This hospital) attended the deceased from <b>Jan 1960</b> to <b>April 3 1965</b> , that (I) (we) last saw the deceased alive on <b>March 25 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Reuben Hoffman</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4-4-65</b>			
23C. PHYSICIAN'S NAME (Type) <b>Reuben Hoffman</b>				23D. ADDRESS M.D. <b>846 W. 36th St.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Poplar Springs.</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co., Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Reuben Hoffman</b>		25C. FUNERAL DIRECTOR <b>Reuben Hoffman</b>		25D. ADDRESS <b>3818 Roland Ave</b>			

832 Madison St.

Box 10, 100

Madison

Alison Bellamy

Also, please return to

White House

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 3627				
BIRTH NO. 65 3627					M.E. CASE NO. 65 3627				
1. NAME OF DECEASED (Type or Print) Robert J. Pfeiffer					2. DATE AND HOUR OF DEATH 3-30-65 5:45 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY Baltimore				
5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital					6. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 5300				
7. STREET ADDRESS (If rural, give location) 85 Dunkirk Rd					8. DATE OF BIRTH 11-11-14				
9. SEX MALE					10. RACE WHITE				
11. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED					12. AGE (In years lost birthday) 50				
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MATERIALS PROCUREMENT					14. KIND OF BUSINESS OR INDUSTRY BENDIX RADIO CORP				
15. BIRTHPLACE (State or foreign country) CONN.					16. CITIZEN OF WHAT COUNTRY? USA				
17. FATHER'S NAME John Pfeiffer					18. MOTHER'S MAIDEN NAME Emma Carlson				
19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO NONE					20. SOCIAL SECURITY NO. 041-09-5346				
21. INFORMANT FAMILY RECORDS					22. ADDRESS				
23. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Hepatic Insufficiency					24. INTERVAL BETWEEN ONSET AND DEATH 5-10 years.				
25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. Jaennee's Cirrhosis					26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				
27. MEDICAL CERTIFICATION 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from 3-15-65 to 3-30-65, that (I) (we) lost saw the deceased alive on 3-30-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Donald A. Deinlein M.D.					23B. DATE SIGNED 3-30-65				
23C. PHYSICIAN'S NAME (Type) DONALD A. Deinlein M.D.					23D. ADDRESS				
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL					24B. DATE APRIL 3, 1965				
24C. NAME OF CEMETERY or CREMATORY DRUID RIDGE CEMETERY					24D. LOCATION (City, town, or county) (State) PIKESVILLE, MD.				
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965					25B. NAME OF REGISTRAR Robert E. Taylor				
25C. FUNERAL DIRECTOR John Brown's Sons, Trueman, Md.					25D. ADDRESS				

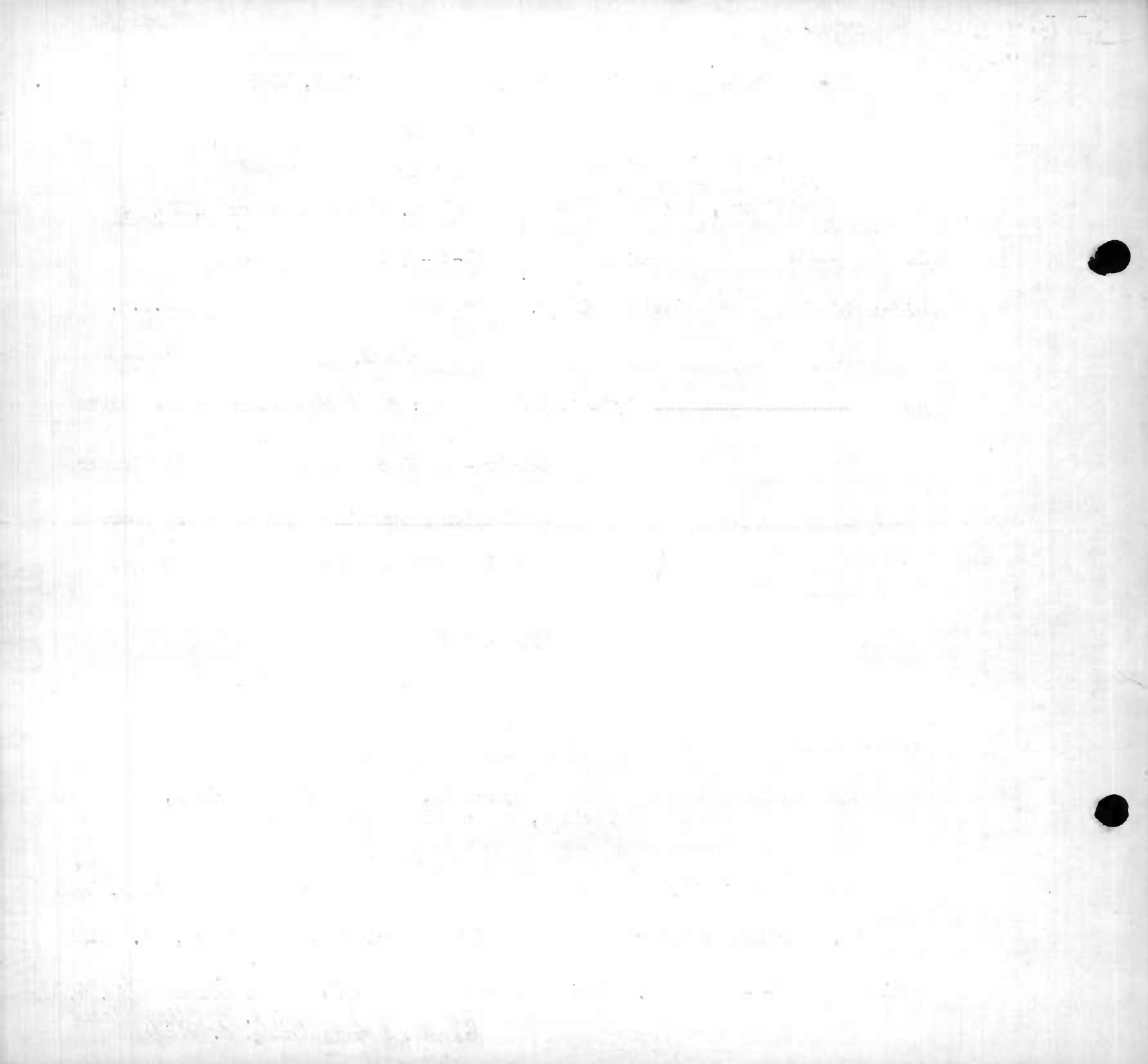




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 3628					CERTIFICATE OF DEATH					Registered No. 65 3628				
1. NAME OF DECEASED (Type or Print) <b>Alouis Schronk (Alois Schronk)</b>										2. DATE AND HOUR OF DEATH <b>April 3, 1965 9:00 P.M.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224</b>										4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-08</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3506 Mt. Pleasant Avenue 21224</b>				
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>11-28-1900</b>		9. AGE (In years last birthday) <b>64</b>		If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Boiler Maker</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Standard Oil Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>Unknown</b>						14. MOTHER'S MAIDEN NAME <b>Unknown</b>								
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>217-03-9104</b>		17. INFORMANT ADDRESS <b>RECORDS: BCH 4940 Eastern Avenue 21224</b>								
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>I</b> (A) <b>Cerebro-Vascular Accident</b> 15 Minutes (B) <b>Aspiration Pneumonia</b> 3 Hours (C) <b>Arteriosclerotic Disease</b> 9 Years ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Hyperpyrexia</b>														
19A. DATE OF OPERATION <b>2</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?						
22. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1965</b> to <b>April 3, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Dr. Charles Carpenter</b>								M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 3, 1965</b>				
23C. PHYSICIAN'S NAME (Type) <b>Dr. Charles Carpenter</b>								23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Md. 21224</b>						
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>4-7-65</b>		24C. NAME of CEMETERY or CREMATORY <b>St. Stanislaus Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>6515 Boston Street Balto. 24, Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>				25B. NAME OF REGISTRAR <b>Robert E. Stalby</b>				25C. FUNERAL DIRECTOR <b>Charles J. Gailer</b>						
ADDRESS <b>901 S. Conkling Street Baltimore, Md. 21224</b>														



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PAUL C. RUNKLE

2. DATE AND HOUR PRONOUNCED DEAD

4-4-65

5:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

MERCY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1128 Barclay Street 20202

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
single

8. DATE OF BIRTH

Feb. 1, 1905

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pennsylvania

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

unknown

14. MOTHER'S MAIDEN NAME

unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)  
no16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Miss Catherine Reynolds, 1128 Barclay Street

18. CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-7-65

23C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Farber

24C. FUNERAL DIRECTOR

Wm. Cook-Brooks, Inc.

ADDRESS

1217 St. Paul Street

WALLACE HOPKINS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT					
CERTIFICATE OF DEATH				Registered No. <u>65 3630</u>	
BIRTH NO. <u>65 3630</u>		M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <u>MARGARET BULL</u>			2. DATE AND HOUR OF DEATH <u>April 5, 1965</u> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Ardleigh Nursing Home</u> <u>2095 Rockrose Avenue</u> <u>Baltimore, Maryland 21211</u>			A. STATE <u>Maryland</u> B. COUNTY <u>12-05</u>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 21201</u>		
			D. STREET ADDRESS (If rural, give location) <u>104 West North Avenue</u>		
5. SEX <u>female</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>widowed</u>	8. DATE OF BIRTH <u>Nov. 1891</u>	9. AGE (In years last birthday) <u>73</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>George Bollinger</u>			14. MOTHER'S MAIDEN NAME <u>Susan Swam</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Lula Bollinger, 1322 Crofton Road, Baltimore</u>	
18. <u>422.1 I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC</u> <u>CARDIO VASCULAR DISEASE</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 YRS.</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>FEB. 9, 1965</u> to <u>APRIL 5, 1965</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>APRIL 3, 1965</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <u>Lloyd E. Saylor</u> M.D.				23B. DATE SIGNED <u>APRIL 5, 1965</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lloyd E. Saylor, M.D.</u>		23D. ADDRESS <u>3902 Greenmount Avenue, Baltimore 18</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4-7-65</u>		24C. NAME of CEMETERY or CREMATORY <u>Druid Ridge Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Pikesville, Md</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Saylor, M.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Wm. Cook-Brooks Inc., 1217 St. Paul Street</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3631		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 3631	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print) EILEEN DAUGHADAY			
2. DATE AND HOUR OF DEATH 4-3-65 8:35 A.M.				3. PLACE OF DEATH IN BALTIMORE, MARYLAND			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE MARYLAND B. COUNTY Balto			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				D. STREET ADDRESS (If rural, give location) 511 WARREN RD Cockeysville			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 6-16-23	9. AGE (In years last birthday) 41	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (State or foreign country) Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Einig				14. MOTHER'S MAIDEN NAME Isabelle McComb			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 219-16-2746		17. INFORMANT ADDRESS Mr Edward R. Daughaday 511 Warren Road			
18. 757.11 CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) UREMIA DUE TO			
ANTECEDENT CAUSES				(B) POLYCYSTIC KIDNEY DUE TO DISEASE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION 13-25-65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED POLYCYSTIC KIDNEY		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At <input type="checkbox"/> At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 3-10-65 to 4-3-65, that (1) (we) last saw the deceased alive on 4-2-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE SALVATORE R. DONOHUE M.D.				23B. DATE SIGNED 4-3-65		23C. PHYSICIAN'S NAME (Type) SALVATORE R. DONOHUE M.D.	
23D. ADDRESS MERCY HOSP.							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-6-65		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		24D. LOCATION (City, town, or county) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR Salvatore [unclear] 7401 [unclear]		ADDRESS	



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100 - 1000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. 65 3632					CERTIFICATE OF DEATH			Registered No. 65 3632	
1. NAME OF DECEASED (Type or Print) <b>Bark, William, Sr.</b>					2. DATE AND HOUR OF DEATH <b>4/3/65 7:15 P.</b>				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Montebello Hospital</b>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1-02</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>20 S. Curley St.</b>				
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>12/31/1891</b>		9. AGE (In years lost birthday) <b>73</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinest</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Unknown RUDOLPH BARK</b>					14. MOTHER'S MAIDEN NAME <b>Mary Fekiszak AUGUSTA</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>					16. SOCIAL SECURITY NO. <b>217-01-1336</b>		17. INFORMANT <b>Hospital Records</b>		
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Squamous Cell Carcinoma of Larynx with metastases to right Lungs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)			INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs.</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>3/29/65</b> 19 to <b>4/3/65</b> 19, that (I) (we) last saw the deceased alive on <b>4/3/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Daniel G. Lai</b>					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>4/3/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Daniel G. Lai</b>					23D. ADDRESS <b>2201 Argonne Drive, Baltimore, Md. 21218</b>				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>4/8/65</b>		24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>			24D. LOCATION (City, town, or county) (State) <b>BALTO. Co. M.D.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>			25B. NAME OF REGISTRAR <b>Robert E. Sals...</b>			25C. FUNERAL DIRECTOR ADDRESS <b>3218 Hudson St.</b>			

— 1000000 —

— 1000000 —

Printed and Published by  
J. H. Johnson & Co. 100 N. 3rd St. N. Y. C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3633				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3633	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
VASILAKIS, EVA				4-2-65		5:50A M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		(If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
ST. AGNES HOSPITAL				MARYLAND		BALTIMORE	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
				ZONE 21224			
				D. STREET ADDRESS (If rural, give location)			
				512 S MACON STREET			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months		If Under 24 Hrs. Days
FEMALE	WHITE	WIDOWED	3-14-92	73			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife		—		GREECE		Greece	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
JAMES DEMETRIOS				MARY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		—		ST. AGNES RECORDS - CATON & WILKENS AVE			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		?	
ANTECEDENT CAUSES				(B) DUE TO		?	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				Diabetes mellitus		25 yrs.	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0				NO			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from APRIL 1 1965 to APRIL 2 1965, that (I) (we) last saw the deceased alive on APRIL 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
William Allen Dean Jr.						4-2-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
				M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4-5-65		Greek Orthodox Cemetery		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 6 1965		R. E. E. Starkey		Nicholas J. Matthews		3021 Eastern Ave. #24	

1961-1962

1963-1964

1965-1966

1967-1968

1969-1970

1971-1972

1973-1974

1975-1976

1977-1978

1979-1980

1981-1982

1983-1984

1985-1986

1987-1988

65 3634

BALTIMORE CITY HEALTH DEPARTMENT

65 3634

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HOWARD GARRETT

2. DATE AND HOUR PRONOUNCED DEAD

April 4, 1965

9:45 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2002 Druid Hill Avenue

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

6-15-1889

9. AGE (In years  
last birthday)

75

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Ind.

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Addison Garrett

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Maggie Garrett 2002 Druid Hill Ave

18. 42211 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Arteriosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Malnutrition and dehydration

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Buried

23B. DATE

4-8-65

23C. NAME of CEMETERY or CREMATORY

Mt Calvary Cem

23D. LOCATION (City, town, or county)

Anne Arundel Co. Md

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

George J. Miller 1348 W. Center

ADDRESS

WALTON

WALTON

WALTON

WALTON

J-612

65 3635

BALTIMORE CITY HEALTH DEPARTMENT

65 3635

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EDWIN B. JARVIS

2. DATE AND HOUR PRONOUNCED DEAD

4-5-65

7:15 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNIVERSITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1519 N. Monroe Street, 21217

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

1-4-23

9. AGE (In years  
last birthday)

42

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

William Jarvis

14. MOTHER'S MAIDEN NAME

Lucy Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Alma Jarvis 3115 Deller St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Fracture of neck  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes - Par.

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Waterview Avenue - West  
of Pottee Street

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year)  
4 5 '65 AM

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Pedestrian struck by  
truck while crossing street

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

XXXXXX

4-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-9-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore Natl. Cem.

23D. LOCATION

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR

George A. Kuhn 1348 N. Calhoun St.



RECEIVED BY THE NATIONAL ARCHIVES

ON 10-10-61

FROM THE NATIONAL ARCHIVES

RECEIVED BY THE NATIONAL ARCHIVES

ON 10-10-61

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ON 10-10-61

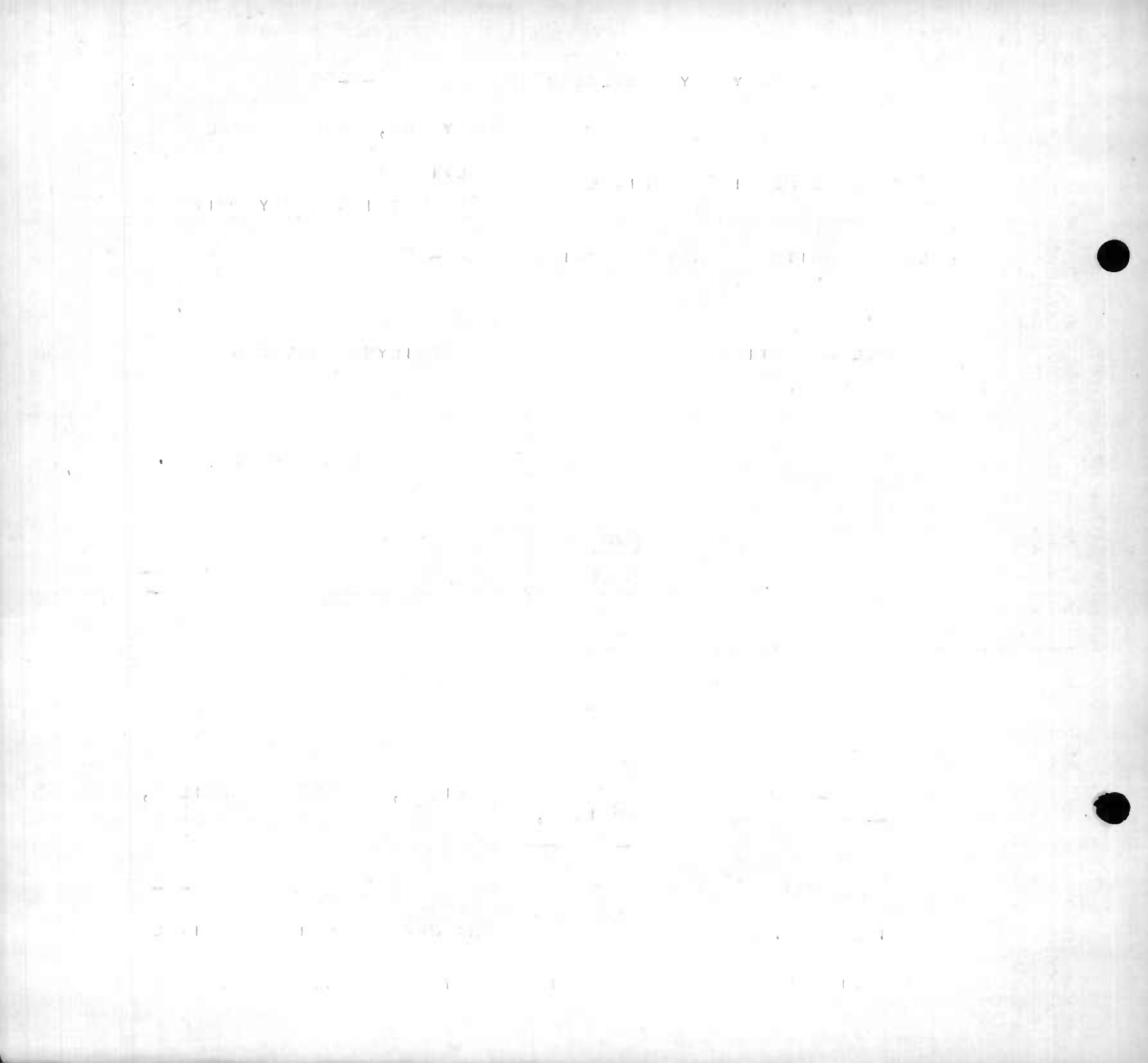
FROM THE NATIONAL ARCHIVES



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65-08380 65-3636		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 65-3636	
M.E. CASE NO.		1. NAME OF DECEASED <b>BABY BOY DONALDSON</b>		2. DATE AND HOUR OF DEATH <b>4-3-65 4:10 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> , B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>5600 PATRICK HENRY DRIVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>4-3-65</b>	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. <b>13 40</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <b>SAMUEL LAMARTINA</b>			
14. MOTHER'S MAIDEN NAME <b>MARILYN DONALDSON</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
18. <b>433.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b> (A) DUE TO  ANTECEDENT CAUSES (B) DUE TO  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <b>APRIL 3, 1965</b> to <b>APRIL 3, 1965</b> , that (I) last saw the deceased alive on <b>APRIL 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Richard H. Heller</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>				23B. DATE SIGNED <b>4-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>RICHARD H. HELLER</b>				23D. ADDRESS M.D. <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>4-3-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>JOHNS HOPKINS HOSPITAL</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE 5, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>			
25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS <b>3642</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 3637</b>	
BIRTH NO. <b>65 3637</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Anna Evelyn Hutchinson</b>			2. DATE AND HOUR OF DEATH <b>April 4/65</b> <b>9P</b> M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ma.</b> B. COUNTY <b>19-04</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Hoods Nursing Home</b> <b>5313 Edmondson Ave.</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 23</b>		
			D. STREET ADDRESS (If rural, give location) <b>Formerly of 1833 Frederick Ave</b>		
5. SEX <b>Female</b>	6. RACE <b>Whitw</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>March 21/90</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Christopher Naber</b>			14. MOTHER'S MAIDEN NAME <b>Anna Iglehart</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT (daughter) <b>Owings Mills, Md</b> <b>Mrs. Frances Fastie, 3 Moales Lane,</b>
18. <b>443X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Hypertension</b> <b>ant scl cv disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <b>15 yr</b> <b>15 yr</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>none</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>no</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) <b>no</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/1 1965</b> to <b>4/4 1965</b> that (I) (we) lost saw the deceased olive on <b>4/1 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mance Feldman</b> M.D.			23B. DATE SIGNED <b>4/6/65</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS M.D.		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/7/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park</b>	
24D. LOCATION <b>Balto. 29, Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Feltz</b>		25C. FUNERAL DIRECTOR <b>Witzke F. D. 4101 Edmondson Ave</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

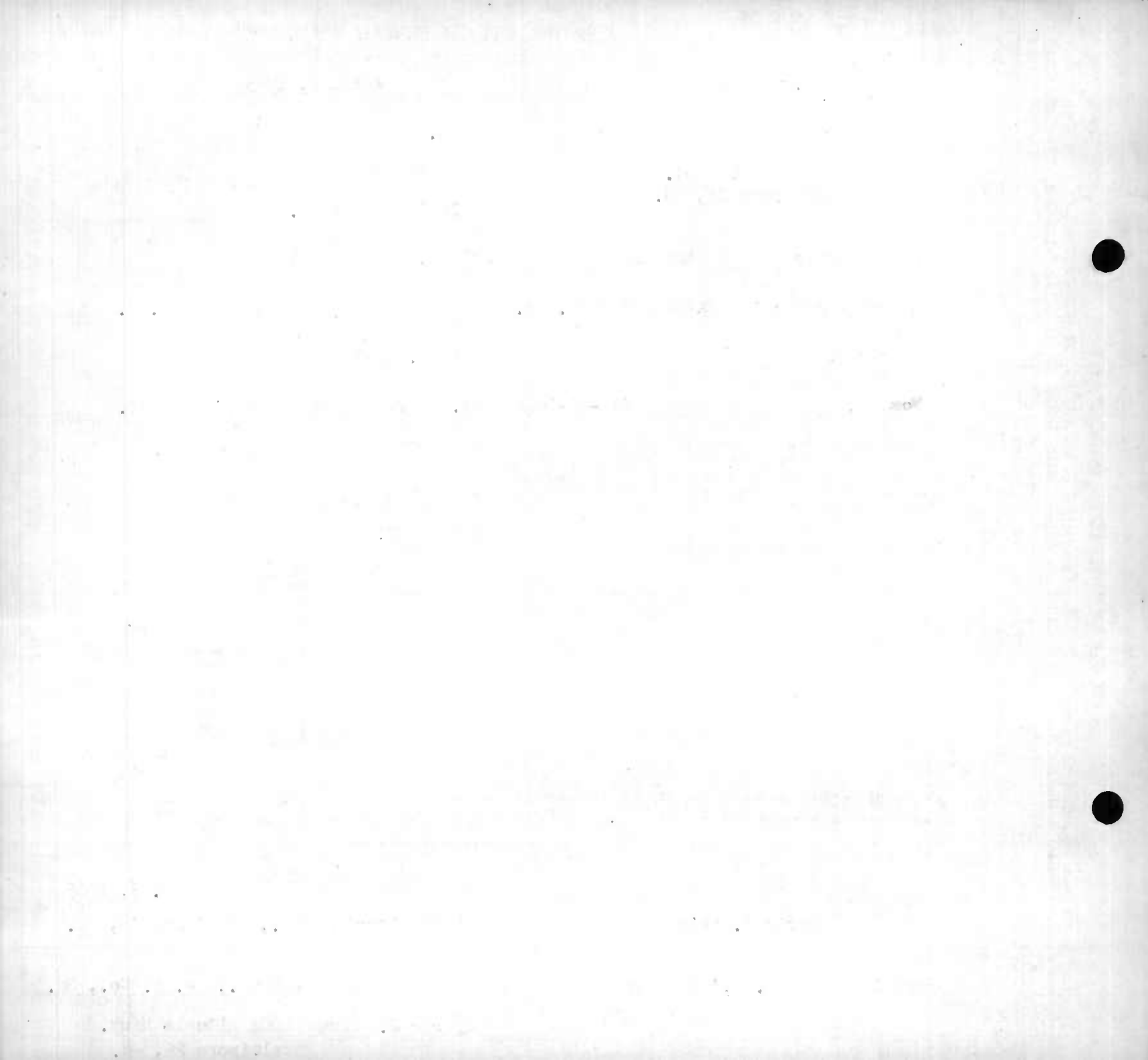
BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					Registered No. 65 3638				
BIRTH NO. 65 3638									
M.E. CASE NO.									
1. NAME OF DECEASED (Type or Print) FRANK LAURENCE CLARK (Clarke)					2. DATE AND HOUR OF DEATH APR 12 5 1965 1 55 A.M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL					C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE				
					D. STREET ADDRESS (If rural, give location) 3714 Brooklyn Ave.				
5. SEX M	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED	8. DATE OF BIRTH 4-23-02	9. AGE (In years lost birthday) 62	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) IRON WORKER		10B. KIND OF BUSINESS OR INDUSTRY CHEMICAL		11. BIRTHPLACE (State or foreign country) NEW JERSEY			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME WILLIAM B. CLARK				14. MOTHER'S MAIDEN NAME MARY M. DERMOTT					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) UNK			16. SOCIAL SECURITY NO. UNK		17. INFORMANT MRS EMILY CLARK		ADDRESS ABOVE		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 130X I CAUSE OF DEATH (A) CARCINOMA of ESOPHAGUS DUE TO ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					INTERVAL BETWEEN ONSET AND DEATH 2YRS				
19A. DATE OF OPERATION ONONG		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A			20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? —		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) N/A		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) N/A		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) N/A					
21D. TIME OF INJURY (APPROX.) N/A		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> N/A		21F. HOW DID INJURY OCCUR? N/A					
22. I certify that (I) (this hospital) attended the deceased from 3-6 1965 to 4-5 1965, that (I) (we) last saw the deceased alive on 4-5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Frederick O. Smith					M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 5 APR 65		
23C. PHYSICIAN'S NAME (Type) FREDERICK O. SMITH					23D. ADDRESS M.D. UNION MEMORIAL HOSPITAL				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-7-1965		24C. NAME OF CEMETERY or CREMATORY Holy Name Cemetery		24D. LOCATION (City, town, or county) (State) Jersey City, N. J.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR 1965000		25C. FUNERAL DIRECTOR George J. Gonce		ADDRESS 4001 Ritchie Hwy. Baltimore 25, Md.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3639	
BIRTH NO. 65 3639				CERTIFICATE OF DEATH	
M.E. CASE NO.				2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) EDWIN C. RECKER				April 5, 1965 11:25 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1521 Elmtree St. Baltimore 25, Md.				A. STATE Md. B. COUNTY Baltimore	
5. SEX Male				6. DATE OF BIRTH July 4, 1897	
7. RACE White				9. AGE (In years last birthday) 67	
8. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married				10. CITIZEN OF WHAT COUNTRY? U. S.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chemical Foreman				11. BIRTHPLACE (State or foreign country) Maryland	
10B. KIND OF BUSINESS OR INDUSTRY Mathieson Chem. Co.				12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Recker				14. MOTHER'S MAIDEN NAME Annie E. Hill	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 215-01-2618	
17. INFORMANT Mrs. Clara Recker				ADDRESS 1521 Elmtree St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) Carcinoma of Rectum w/ Metastases to lungs (B) Abdomen (C) INTERVAL BETWEEN ONSET AND DEATH 6 months					
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
21. DATE OF OPERATION				22. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
23. CONDITION FOR WHICH OPERATION WAS PERFORMED				24. AUTOPSY? (Yes or No)	
25. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)				26. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
27. TIME OF INJURY (Month) (Day) (Year) (Hour)				28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
29. INJURY OCCURRED				30. HOW DID INJURY OCCUR?	
31. I certify that (I) (this hospital) attended the deceased from January 1965 to April 1965, that (I) (we) last saw the deceased alive on March 31, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
32. SIGNATURE Mario J. Reda				33. DATE SIGNED Apr. 5, 1965	
34. PHYSICIAN'S NAME (Type) Mario J. Reda				35. ADDRESS 4016 Ritchie Hwy., Baltimore 25, Md.	
36. BURIAL CREMATION, REMOVAL (Specify) Burial				37. DATE Apr. 8, '65	
38. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery				39. LOCATION Ritchie Hwy., A. A. Co., Md.	
40. DATE REC'D BY HEALTH DEPT. APR 6 1965				41. NAME OF REGISTRAR George J. Conce	
42. FUNERAL DIRECTOR ADDRESS 4001 Ritchie Hwy. Baltimore 25, Md.					

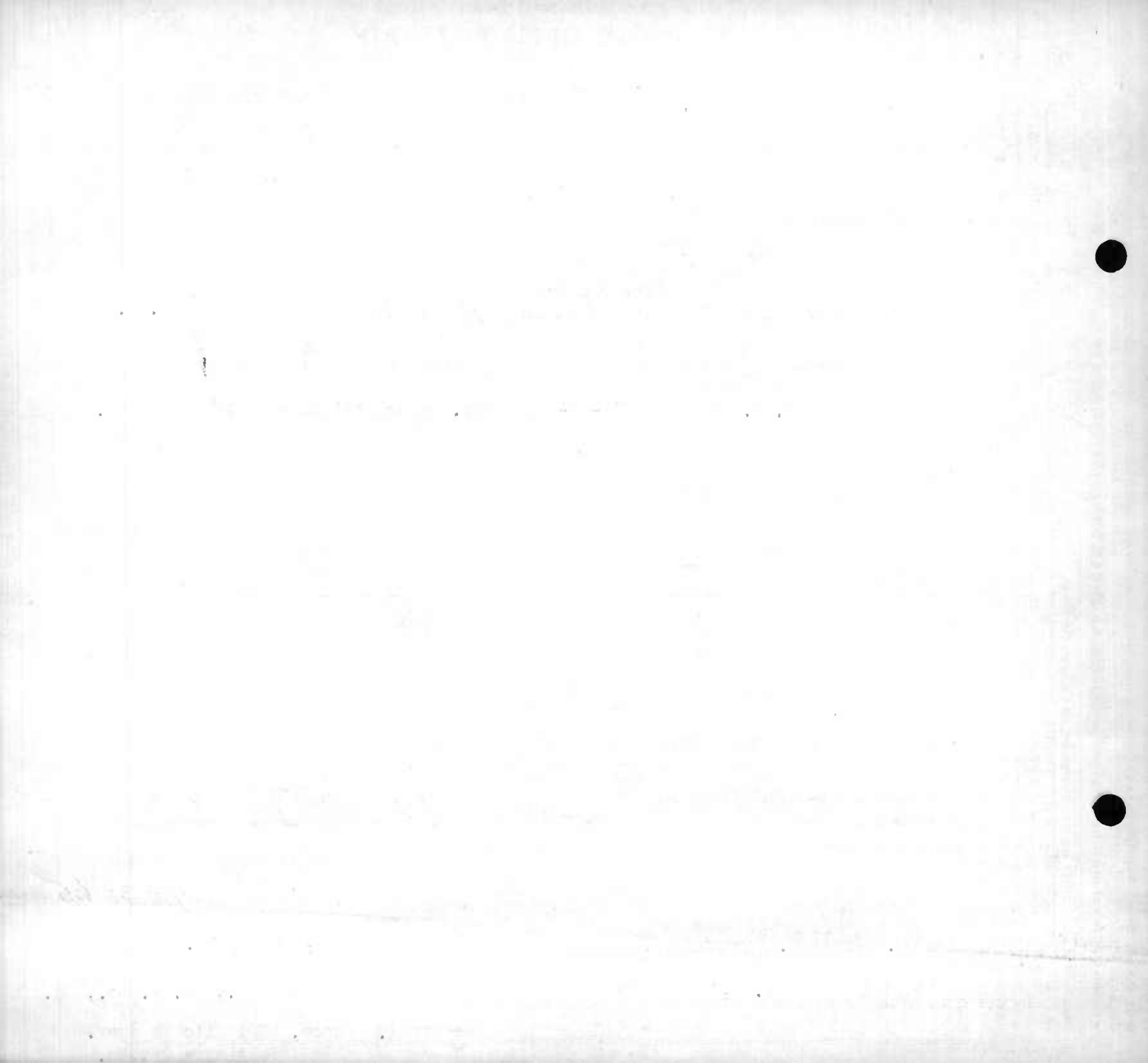




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

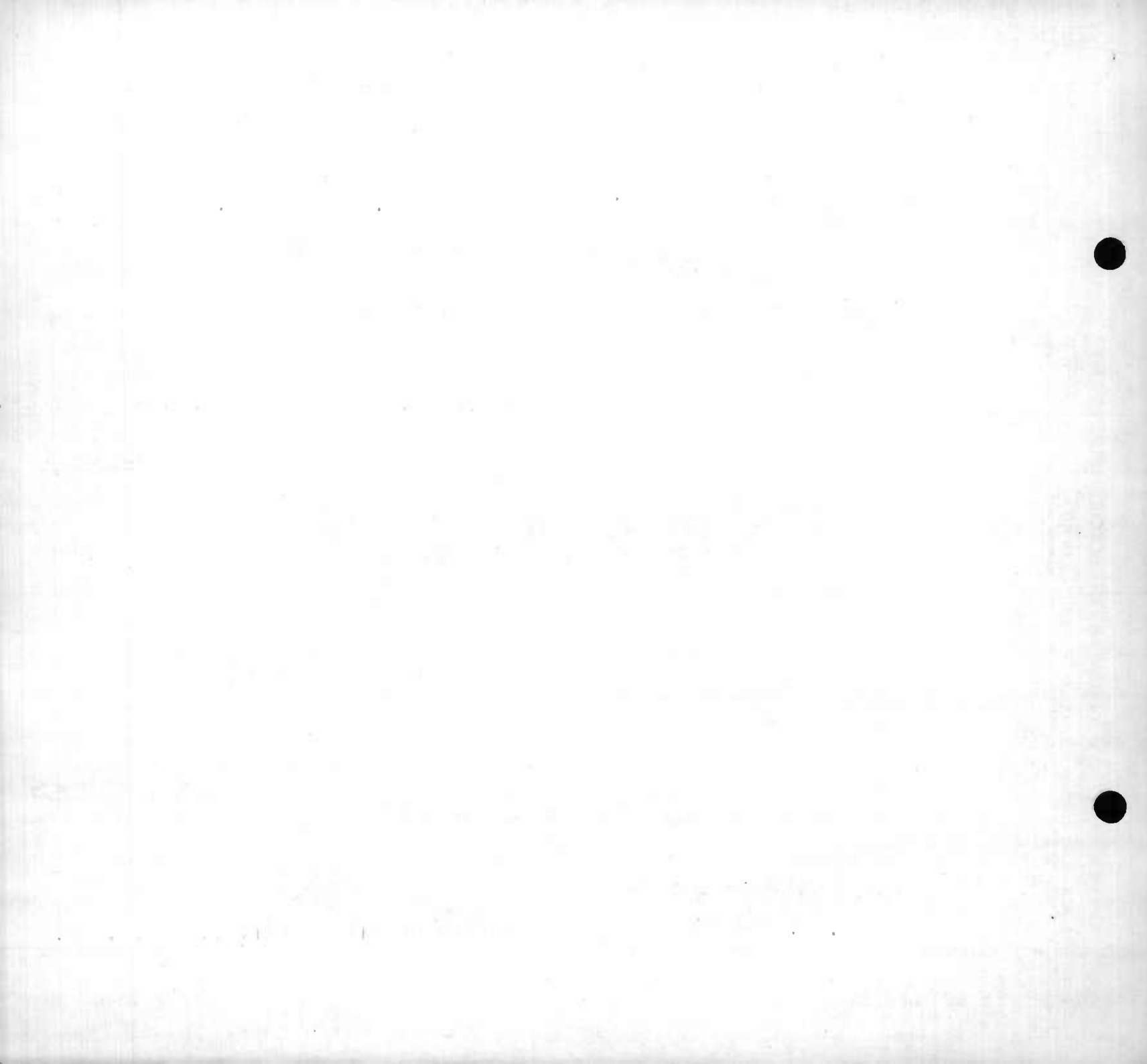
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3640	
BIRTH NO. 65 3640		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Roy J. Bartolomeo		2. DATE AND HOUR OF DEATH 4-3-65 10:15 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION South Baltimore General Hosp.		A. STATE Maryland B. COUNTY Baltimore # 212 25. C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location) 4201 3rd. St. 62-00			
5. SEX M.	6. RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married	8. DATE OF BIRTH 3-15-23	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steamfitter		10B. KIND OF BUSINESS OR INDUSTRY Construction Steamfitter		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Louis Bartolomeo		14. MOTHER'S MAIDEN NAME Julia Rollan	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes W. W. II		16. SOCIAL SECURITY NO. 217-12-9434		17. INFORMANT Mrs. Agnes Bartolomeo 4201 Third St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Pulmonary Embolism DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <del>this</del> (this hospital) attended the deceased from 3-22-65 to 4-3-65 that <del>we</del> (we) last saw the deceased alive on 4-3-65 and that in <del>last</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Kermit P. Bonovich		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4-3-65	
23C. PHYSICIAN'S NAME (Type) Dr. Kermit P. Bonovich		23D. ADDRESS M.D. 1213 Light Street, Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Apr. 7, '65		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION Ritchie Hwy., A. A. Co., Md.		24E. STATE (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. Stahler		25C. FUNERAL DIRECTOR George J. Gonce, 4001 Ritchie Hwy. Baltimore 25, Md.	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. — 65 3641	
BIRTH NO. 65 3641		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MORRIS LEVIN		2. DATE AND HOUR OF DEATH 4-4-65 10:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 5	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JOHNS HOPKINS HOSPITAL.		D. STREET ADDRESS (If rural, give location) 537 N. CHESTER ST.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) WIDOWED	8. DATE OF BIRTH 1-25-92	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MERCHANT		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) RUSSIA	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME ISADORE		14. MOTHER'S MAIDEN NAME SELDA			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-20-5094		17. INFORMANT BENTAMIN GOODMAN KAYANACH. RD #2	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) PNEUMONIA (B) ASPIRATION (C) CVA		INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3:25 to 4:4 19 65, and that (I) (the hospital) last saw the deceased alive on 11:45 4:4 19 65, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.					
23A. SIGNATURE DR. W. MAXSON		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4.9.65	
23C. PHYSICIAN'S NAME (Type) DR. W. MAXSON		23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL, BALTO. MD.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL	24B. DATE 4-6-65	24C. NAME OF CEMETERY or CREMATORY MT CARMEL	24D. LOCATION (City, town, or county) BALTIMORE MD. (State)		
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Jack Helms Inc 2100 E. Main Pl	



65 3642

BALTIMORE CITY HEALTH DEPARTMENT

65 3642

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES SCROGGINS

2. DATE AND HOUR PRONOUNCED DEAD

March 16, 1965 2:45 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

Baltimore City Hospital

Baltimore City Hospital

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

(B) DUE TO

(C)

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-17-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

23B. DATE

APR 5 1965

23C. NAME OF CEMETERY OR CREMATORY

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Fagbemi

24C. FUNERAL DIRECTOR

ADDRESS

MORTUARY SERVICE - BCHB

VALLEY FORGE

PAID BY

*Handwritten signature*

65 3643

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 65 3643

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Ignatius Krygier

2. DATE AND HOUR OF DEATH

3-22-65

11:00 A. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

8. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1117 East Pratt Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

1-20-93

9. AGE (In years  
last birthday)

72

If Under 1 Yr. If Under 24 Hrs.  
Months: Days: Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18. 465 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) ? Pulmonary Embolus  
DUE TO

6 Hours

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B)  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Chronic Lung Disease

Years

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

White At  
Work ☐Not White  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-15- 19 65 to 3-22- 19 65,  
that (I) (we) last saw the deceased alive on 3-22 19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

3-22-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Marvin Schuster

M.D.

4940 Eastern Avenue

#21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

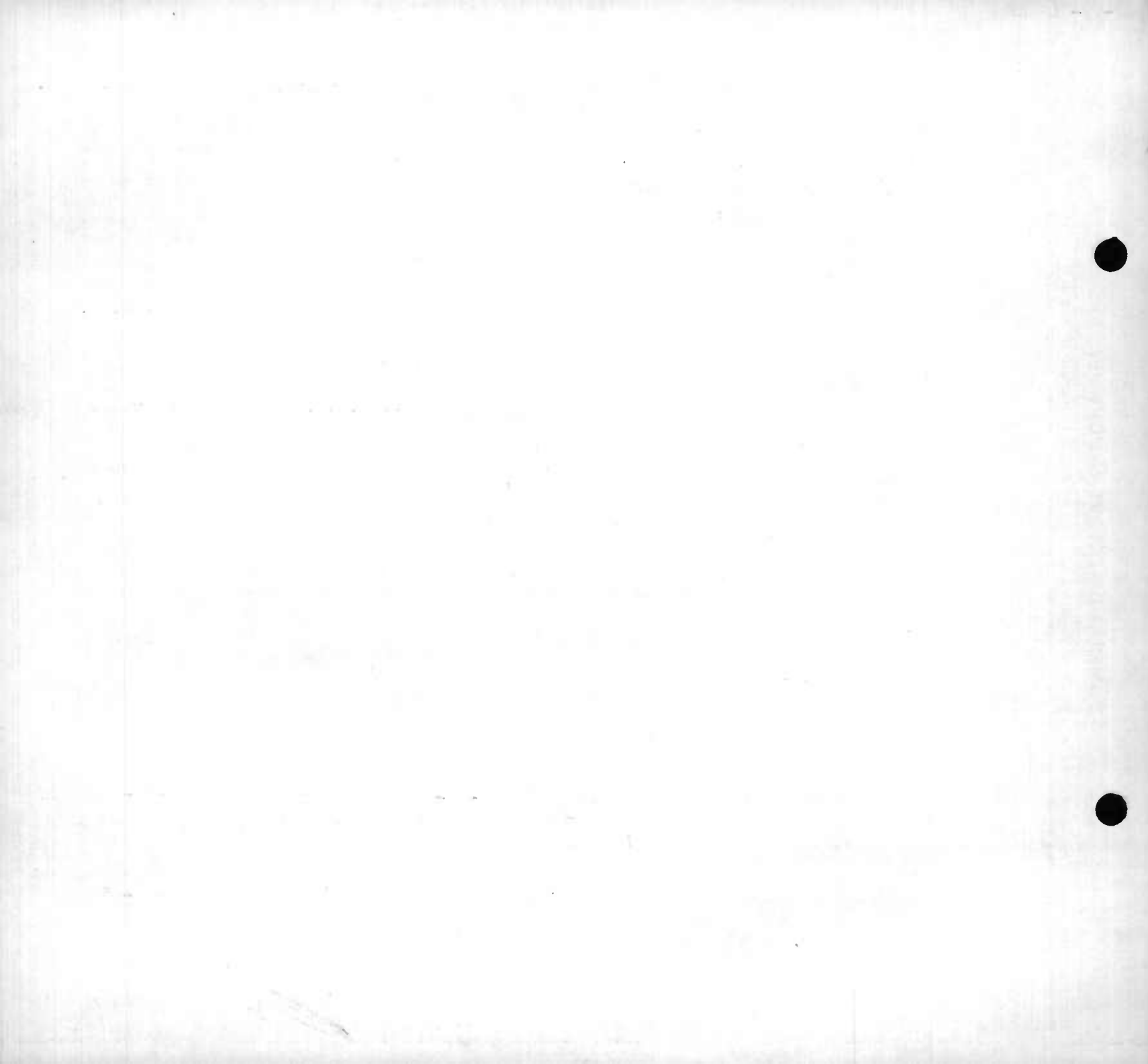
APR 6 1965

APR 6 1965

UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - B.C.H.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

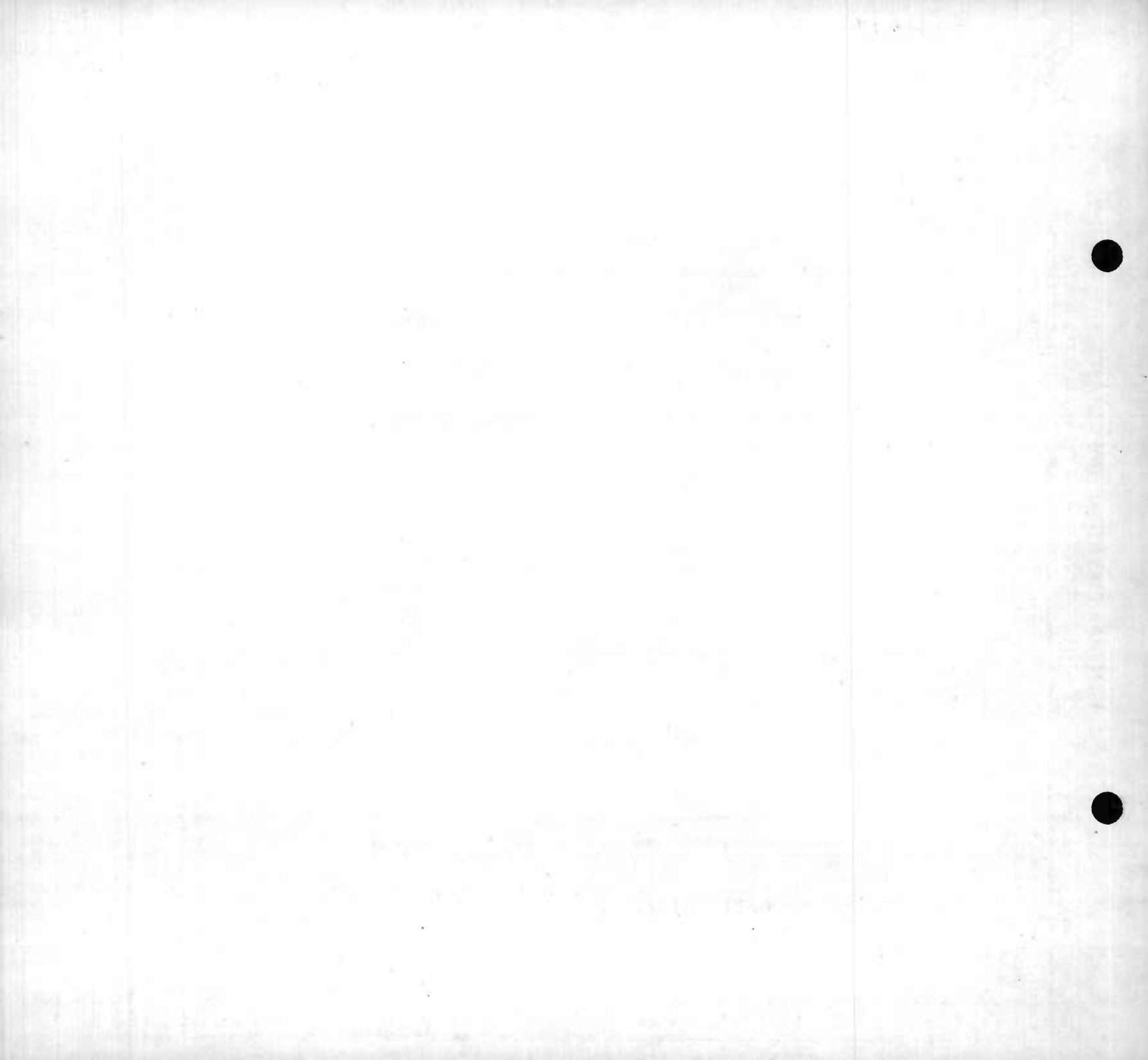




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

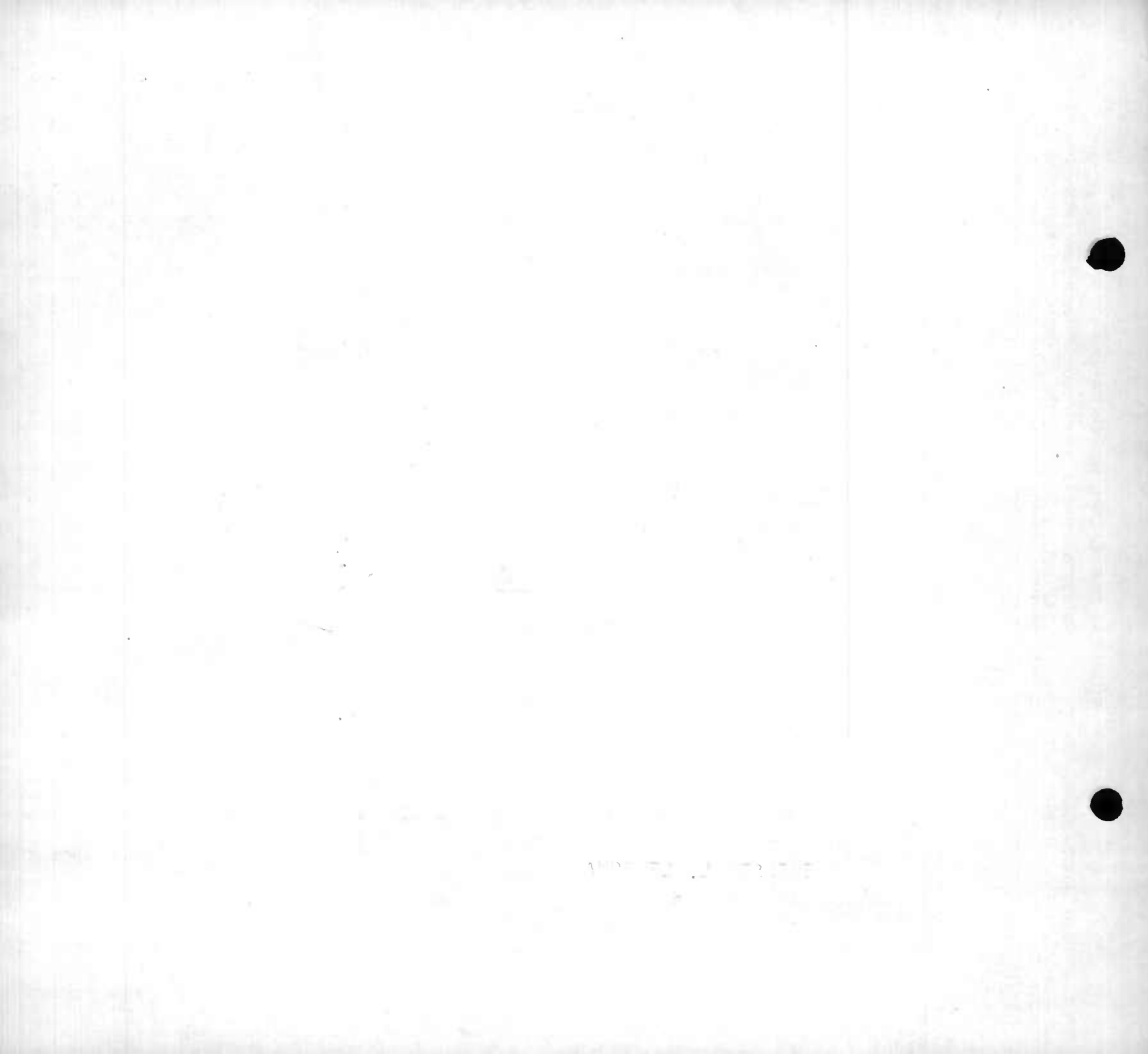
BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65-0621065 3644</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 3644</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Bryant Baby Boy</b>		2. DATE AND HOUR OF DEATH <b>3-18-65 1:50 A.M.</b>	
3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hosp Baltore</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>704 Aisquith St 21202</b>			
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>never married</b>	8. DATE OF BIRTH <b>3/16/65 5:43 PM</b>	9. AGE (in years last birthday) <b>0 1 8 7</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Russell Bryant</b>			14. MOTHER'S MAIDEN NAME <b>Shirley Jean Gooding</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>mother</b>		ADDRESS <b>above</b>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>226X I</b>		CAUSE OF DEATH (A) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO <b>Immaturity</b>		<b>life</b>	
(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		20A. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/16/65</b> 19 to <b>3/18/65</b> 19 that (I) (we) last saw the deceased alive on <b>3/15/65</b> 19 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Mitchell Sollod</b>				23B. DATE SIGNED <b>3/18/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Mitchell Sollod M.D.</b>		23D. ADDRESS <b>UNIV. HOSP BALTO MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>MAR 29 1965</b>		24B. DATE		24C. NAME OF CEMETERY or CREMATORY <b>ANTHONY BOARD OF MARYLAND</b>	
24D. LOCATION <b>UNIVERSITY MEDICAL SCHOOL</b>		24E. ADDRESS <b>MORTUARY SERVICE - BCHD</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. <u>65-07218</u> <u>65</u> <u>3645</u>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <u>65</u> <u>3645</u> <u>4</u>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>BABY BOY HEATH</u>		2. DATE AND HOUR OF DEATH <u>3/26/65</u> <u>11:30</u> a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Union Memorial Hosp.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BELTAR</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BELTAR</u> D. STREET ADDRESS (If rural, give location) <u>P.O. BOX 43</u> <u>62-00</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Never married</u>	8. DATE OF BIRTH <u>3/25/65</u>	9. AGE (In years lost birthday) <u>1</u> <u>45</u>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John HEATH</u>		14. MOTHER'S MAIDEN NAME <u>WRETHA ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>1</u> ADDRESS	
18. <u>726X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Immaturity, 450 Grams approx. 23 wks. gestation</u> (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr. 45 min.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>3/26</u> <u>1965</u> to <u>3/26</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>11:30 am 3/26</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>ERNESTO L. LEDESMA</u> M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>3/26/65</u>		23C. PHYSICIAN'S NAME (Type) <u>ERNESTO L. LEDESMA</u>	
23D. ADDRESS <u>Union Memorial Hosp.</u>		24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <u>MAR 29 1965</u>			
24C. NAME OF CEMETERY or CREMATORY <u>UNIVERSITY MEDICAL SCHOOL</u>		24D. LOCATION (City, town, or county) (State) <u>MORTUARY SERVICE - BCHD</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Fink</u>		25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>	



65 3646

BALTIMORE CITY HEALTH DEPARTMENT

65 3646

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM COURM

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965

10:10 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Josephs Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

718 E. Chase St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Aug 18, 1908

9. AGE (In years  
last birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Courm

14. MOTHER'S MAIDEN NAME

Ellis

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Jennie Lee Courm 718 E. Chase St

18. 4221 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
m. WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

April 7/65

23C. NAME of CEMETERY or CREMATORY

Carmel Memorial Park

23D. LOCATION

(City, town, or county)

(State)

Laurel Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 6 1965

Robert E. Taylor

Milton E. Elickson

1129 N. Carroll St

Milton E. Elickson

W. H. R. H. H.

James Smith's Green Mountain Route N.Y.

W. H. R. H. H.

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3647

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EULA HOCKER

2. DATE AND HOUR PRONOUNCED DEAD

March 31, 1965 11:05 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2220 E. Biddle St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

married

8. DATE OF BIRTH

Jan. 7, 1930

9. AGE (in years  
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Winterville, N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, go on unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Bruce Hocker 2220 E. Biddle St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Recent myocardial infarction  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Coronary arteriosclerotic heart disease  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

3-31-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

April 5/65

23C. NAME OF CEMETERY or CREMATORY

Bald, Natl. Cem.

23D. LOCATION (City, town, or county)

5301 Bruck Ave. Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 6, 1965

24B. NAME OF REGISTRAR

Robert E. Felt

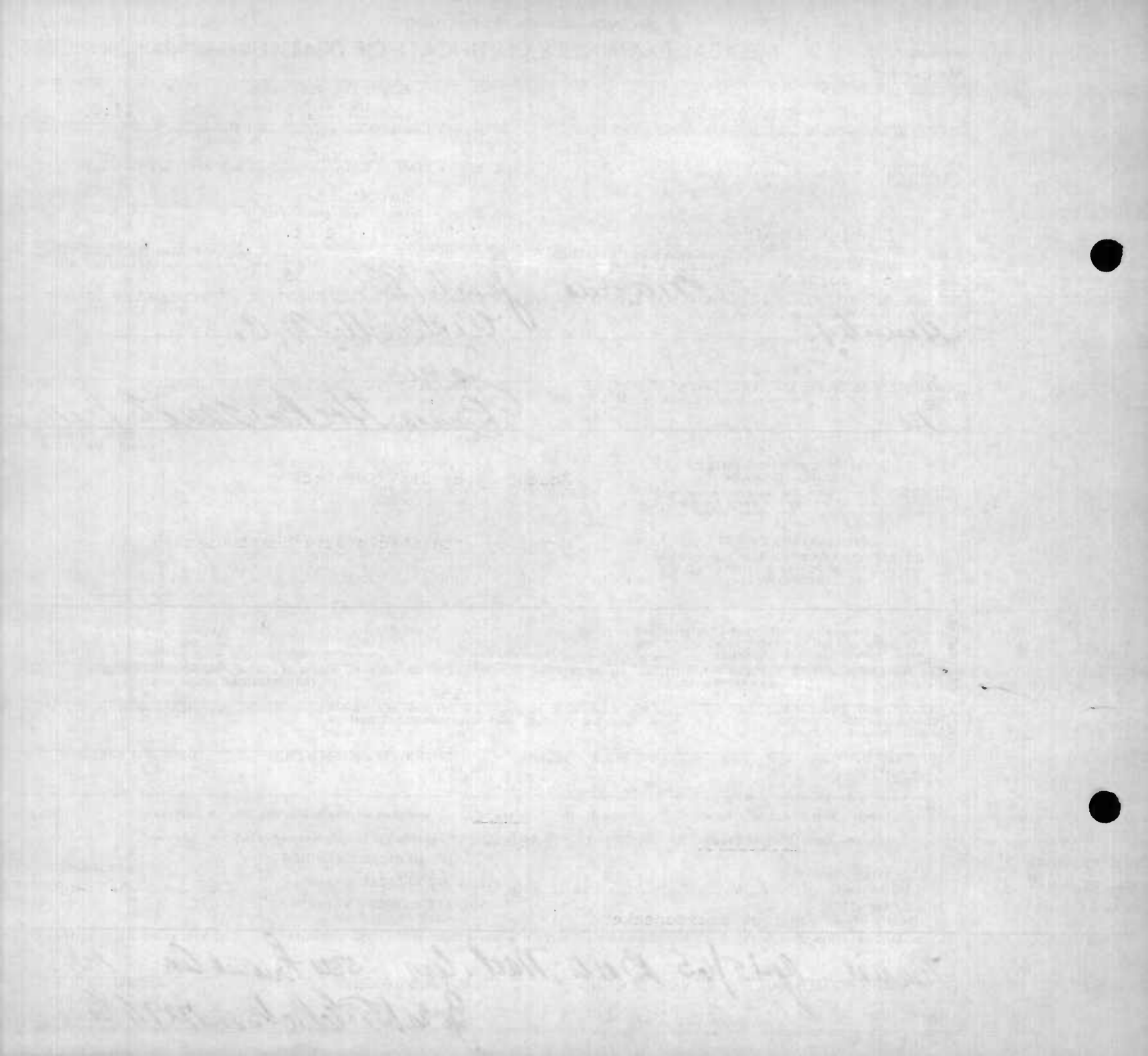
24C. FUNERAL DIRECTOR

John T. Erickson

ADDRESS

12971 Caroline St



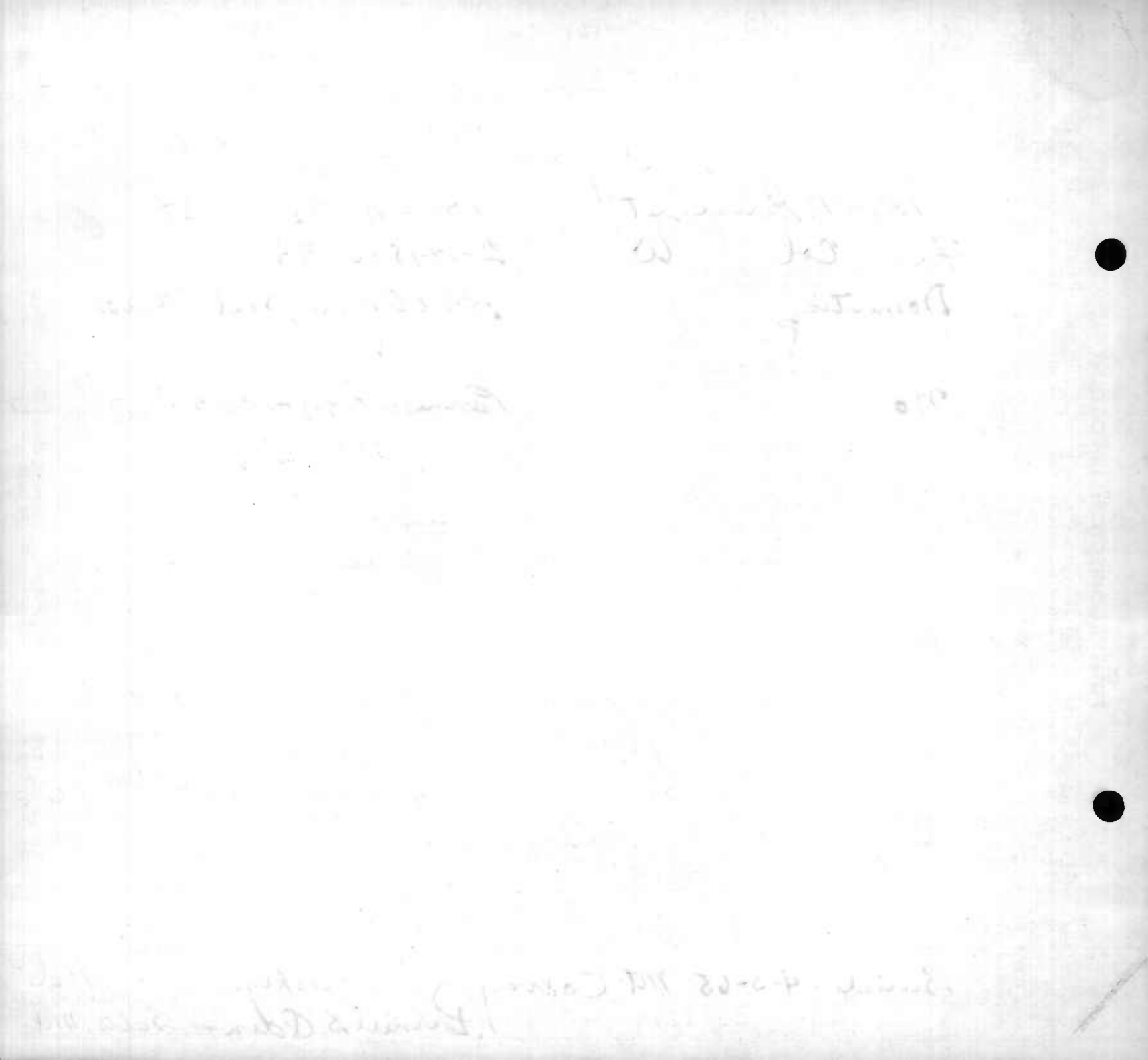




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. 65 3648		CERTIFICATE OF DEATH		65 3648	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>EMMA PRAZIER</b>		2. DATE AND HOUR OF DEATH <b>4-2-65 7:00 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>md</b> B. COUNTY <b>15-02</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>La Plaza Nursing Home</b> <b>1515 N. Bruce St</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
		D. STREET ADDRESS (If rural, give location) <b>1515 N. Bruce St</b>			
5. SEX <b>Fe</b>	6. RACE <b>Col</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>W.</b>	8. DATE OF BIRTH <b>2-14-1880</b>	9. AGE (In years lost birthday) <b>85</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, md</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Bernice Fogg - 1515 N. Bruce St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Coronary thrombosis</b>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) DUE TO <b>Ess Hypertension</b>		<b>30 yrs -</b>	
		(B) DUE TO <b>Hyper + Dilatation - Heart</b>		<b>30 yrs -</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>7-22-1961</b> to <b>4-2-1965</b> that (I) (we) last saw the deceased alive on <b>4-1-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Geo. H. Pendleton</b>				23B. DATE SIGNED <b>4-2-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Geo. H. Pendleton</b>				23D. ADDRESS <b>1723 Druid Hill Ave</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-3-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary</b>	
24D. LOCATION <b>Brooklyn md</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Stachurski</b>	
25C. FUNERAL DIRECTOR <b>Paul H. Oden</b>		25D. ADDRESS <b>Baltimore, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				Registered No. 65 3649	
BIRTH NO. 65 3649		CERTIFICATE OF DEATH		Registered No. 65 3649	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>Dora Nichols</i>		2. DATE AND HOUR OF DEATH <i>March 28, 1965 7:45 A.M.</i>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>4-02</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>7709 West Fayette ST.</i>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>University Hospital</i>		D. STREET ADDRESS (If rural, give location) <i>BALTIMORE 1, Maryland</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>1/1/1904</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>NORTH CAROLINA</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>DANIEL ELLIOTT</i>		14. MOTHER'S MAIDEN NAME <i>HANAH ?</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>George Nichols (Husband)</i>	
18. <i>450.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Pulmonary Embolus</i> DUE TO (B) <i>Gangrene R Leg</i> DUE TO (C) <i>Generalized Arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>II</i> <i>Arteriosclerotic heart disease</i>		19A. DATE OF OPERATION <i>3/23/65</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Gangrene R Leg</i>	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from <i>March 23</i> 19 <i>65</i> to <i>March 28</i> 19 <i>65</i> , that (we) last saw the deceased alive on <i>March 28</i> 19 <i>65</i> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Bruce H. MacPherson</i>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>3/28/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Bruce H. MacPherson</i>		23D. ADDRESS <i>M.D.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4-3-65</i>		24C. NAME OF CEMETERY or CREMATORY <i>mt Auburn</i>	
24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>		25A. DATE REC'D BY HEALTH DEPT. <i>APR 6 1965</i>			
25B. NAME OF REGISTRAR <i>Robert E. Stash...</i>		25C. FUNERAL DIRECTOR <i>Wm Reese II - Annapolis, Md</i>			

1904

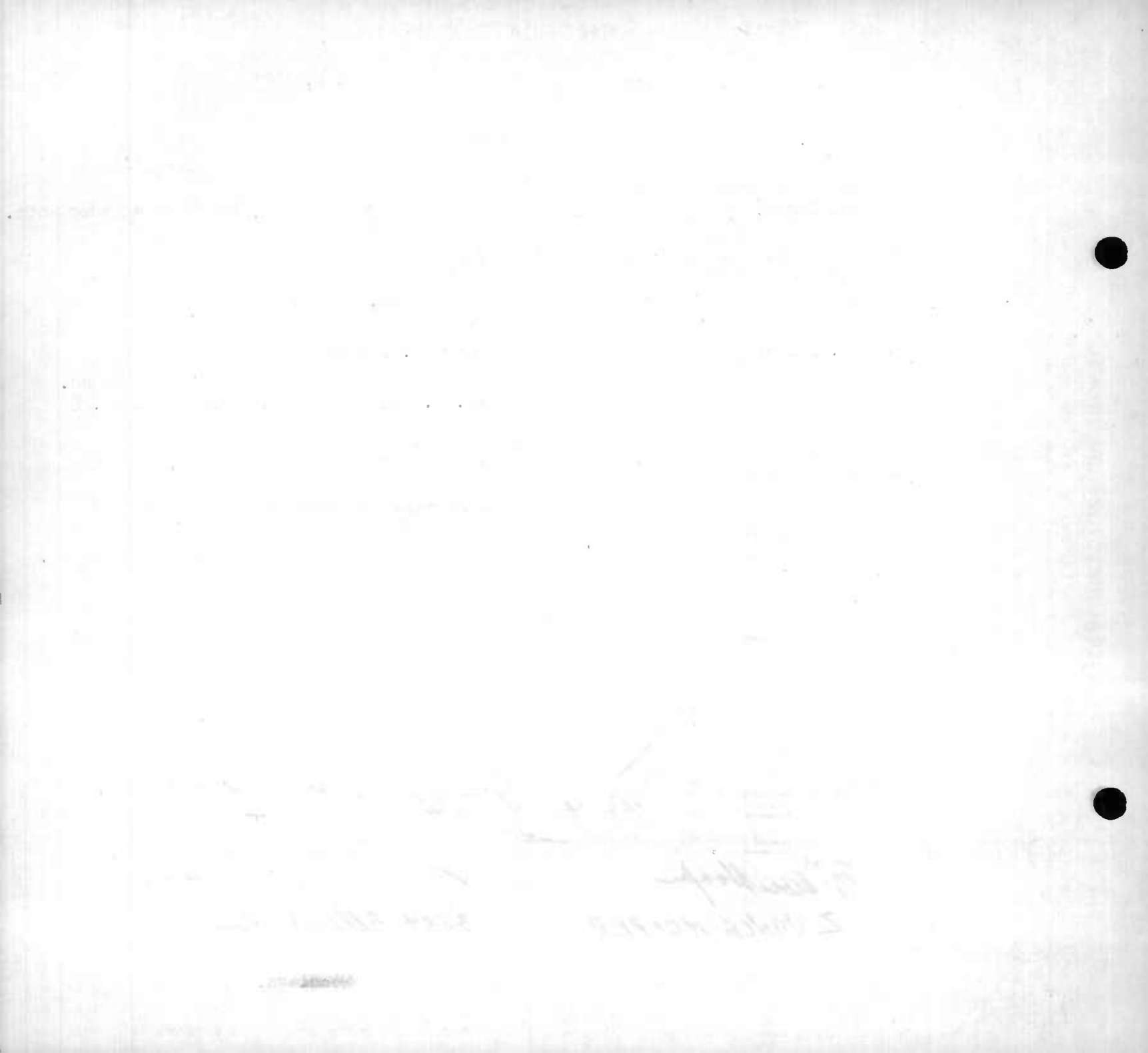
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London, W.C.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

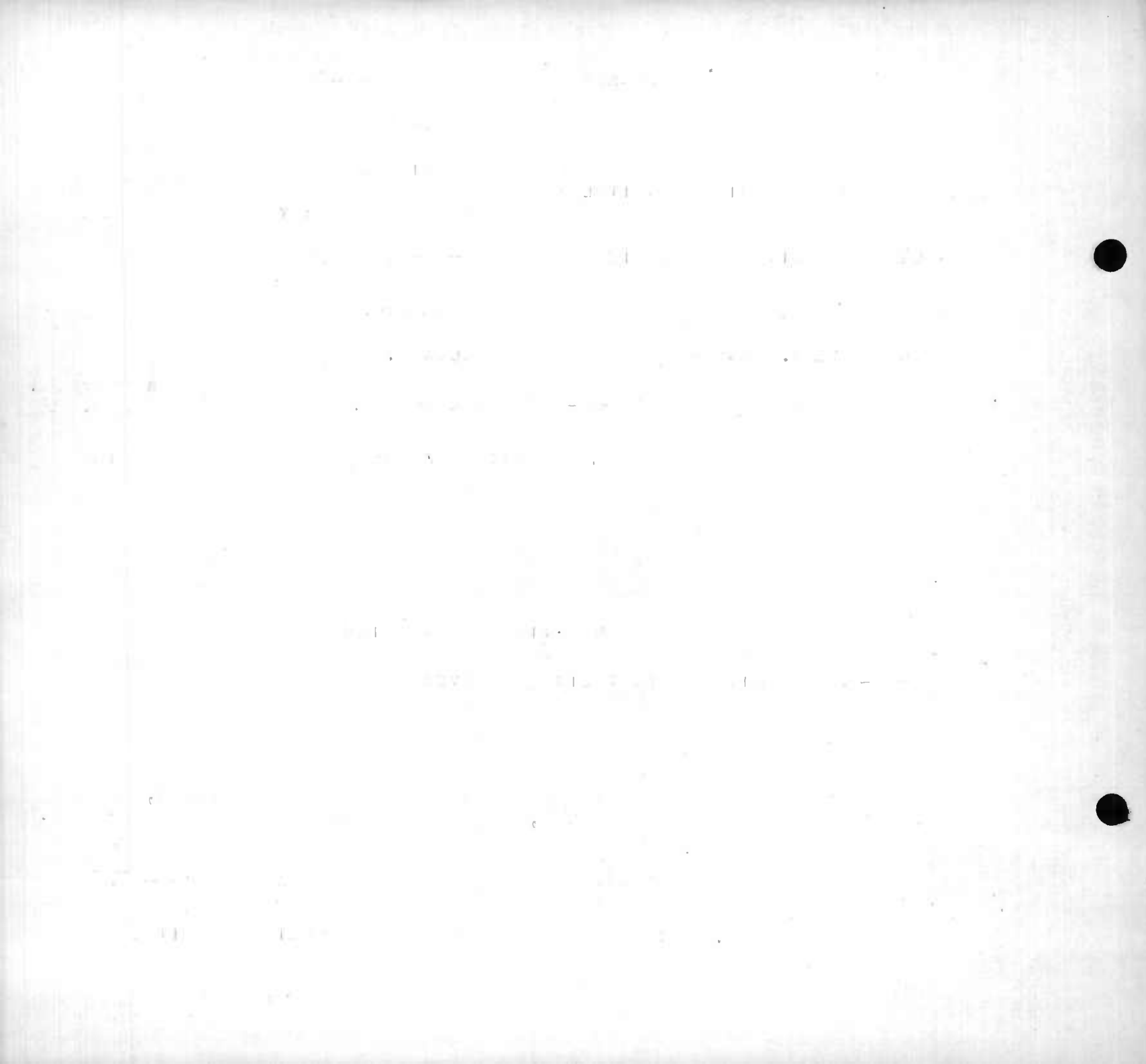
BIRTH NO. 65 3650		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3650	
M.E. CASE NO.			1. NAME OF DECEASED		
(Type or Print)			Blanche Holmes Myers		
2. DATE AND HOUR OF DEATH			April 4, 1965 830 A M.		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Century Nursing Home 102 North Paca Street Baltimore, Maryland 21201			Maryland C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) Canterbury and 39th Street Ambassador Apts.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
Female	White	Widowed	9/7/1869	95	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Homemaker			Baltimore, Maryland		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
William G. Holmes			Mary E. Tucker		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
			No		
17. INFORMANT			ADDRESS		
Mrs. H. Nelson Warfield			7025 Plymouth Rd. Baltimore, Md. 8		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) Serility -		
ANTECEDENT CAUSES			(B) Arterio Sclerosis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
0			X		
20A. AUTOPSY? (Yes or No)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
No			No		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.)		
21E. INJURY OCCURRED			21F. HOW DID INJURY OCCUR?		
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from Jan 15 1965 to 4-4 1965, that (I) (we) last saw the deceased alive on 4-4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Z. VANCE HOOPER			4-6-65		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
Z. VANCE HOOPER			3534 Ellerslie Ave		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/6/1965		Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State)		24E. DATE REC'D BY HEALTH DEPT.		24F. NAME OF REGISTRAR	
Woodlawn, Maryland		APR 6 1965		R. G. E. Staley	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 6 1965		R. G. E. Staley		Wm. J. Fisher & Sons	
25D. ADDRESS		25E. ADDRESS		25F. ADDRESS	
Baltimore, Md. 21217		Baltimore, Md. 21217		Baltimore, Md. 21217	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3651				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3651	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>A. THEODORE MASTERMAN</b>				2. DATE AND HOUR OF DEATH <b>4-3-65</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>12 01</b>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>			
				D. STREET ADDRESS (If rural, give location) <b>3811 CANTERBURY ROAD 21218</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>6-11-89</b>		9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>President</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Royal Oak Building</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>THEODORE A. Masterman</b>				14. MOTHER'S MAIDEN NAME <b>ELLA G. AMOS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-16-0497</b>		17. INFORMANT <b>Mrs. Helen A. Masterman</b> ADDRESS <b>3811 Canterbury Rd. Baltimore, Md. 18</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CANCER OF COLON</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 MONTHS</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>CONGESTIVE HEART FAILURE</b>							
19A. DATE OF OPERATION <b>2-17-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>LIVER METASTASIS</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>NOVEMBER 19 64</b> to <b>APRIL 3, 19 65</b> , that (I) (we) last saw the deceased alive on <b>APRIL 3, 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Gerald A. Acker</b> M.D.				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4-3-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>GERALD A. ACKER</b> M.D.				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/7/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staskewich</b>		25C. FUNERAL DIRECTOR <b>Wm. F. Tietzen &amp; Sons</b> ADDRESS <b>Balt., Md. 21217</b>			





FUNERAL DIRECTOR: IMPORTANT

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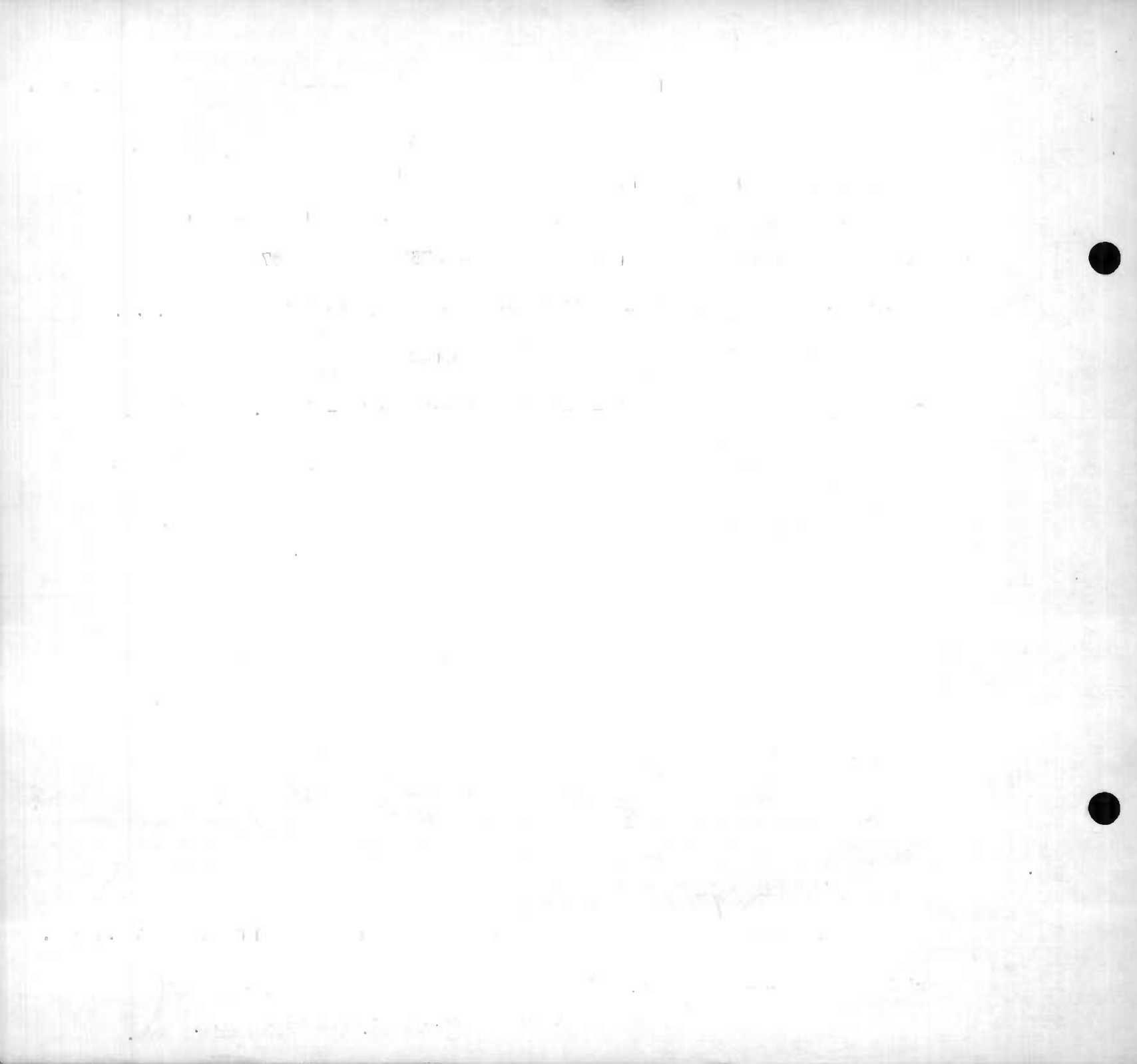
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 3652</u>	
BIRTH NO. <u>65 3652</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Kemp, DeWitt, E. Sr.</u>		2. DATE AND HOUR OF DEATH <u>4/5/65 6:15 AM.</u>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hosp of Md.</u>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
		D. STREET ADDRESS (If rural, give location) <u>3600 Kelox Rd. 21207</u>			
5. SEX <u>Male</u>	6. RACE <u>white</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Married</u>	8. DATE OF BIRTH <u>1/12/89</u>	9. AGE (In years lost birthday) <u>76 years</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Treasurer</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Retail Milk Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>DeWitt Clinton Kemp</u>		14. MOTHER'S MAIDEN NAME <u>Frances Brunner</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Mary Louise Kemp</u>	
				ADDRESS <u>3600 Kelox Road Baltimore, Md. 21207</u>	
18. <u>331X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>C.V.A.</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Cardiovascular accident.</u>		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-28-65</u> to <u>4-5-65</u> , that (I) (we) last saw the deceased alive on <u>4/5/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <u>6:15 AM.</u>					
23A. SIGNATURE <u>Rajae</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/5/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>SARCOOSH RAJAE</u>		23D. ADDRESS <u>Martin Dams</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/7/1965</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Olivet Cemetery</u>	
				24D. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Johnson</u>		25C. FUNERAL DIRECTOR <u>Wm. A. Johnson</u>	
				ADDRESS <u>Balt. Md. 21217 North L. Pa. Ave</u>	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3653		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3653	
M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) <b>BERNARD CRAIG</b>			2. DATE AND HOUR OF DEATH <b>4-5-65</b> <b>5:30 A.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>7-03</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 5</b> D. STREET ADDRESS (If rural, give location) <b>623 N. MADEIRA STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>1-1-78</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chauffeur</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AGRICO - Fertilizers</b>		11. BIRTHPLACE (State or foreign country) <b>Warrenton, Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>LAWSON</b>		
14. MOTHER'S MAIDEN NAME <b>ALICE</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>213-09-9929</b>			17. INFORMANT <b>Alverta Craig - 623 N. Maderia Street</b>		
18. <b>331X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CVA</b>			INTERVAL BETWEEN ONSET AND DEATH <b>14D</b> <b>15D</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3.21. 65</b> to <b>4.5. 65</b> , that (I) <del>lost</del> saw the deceased alive on <b>5.30 4.5 19 65</b> and that in (my) <del>opinion</del> death occurred on the date and hour and from the causes stated above. (I) <del>did</del> <del>not</del> view the body after death.					
23A. SIGNATURE <b>Wm. Maxson</b>				23B. DATE SIGNED <b>4.5.65</b>	
23C. PHYSICIAN'S NAME (Type) <b>WM. MAXSON</b>				23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL, BALTO., MD.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-8-65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>			
25B. NAME OF REGISTRAR <b>Charles B. Law</b>		25C. FUNERAL DIRECTOR <b>802 Madison Ave.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

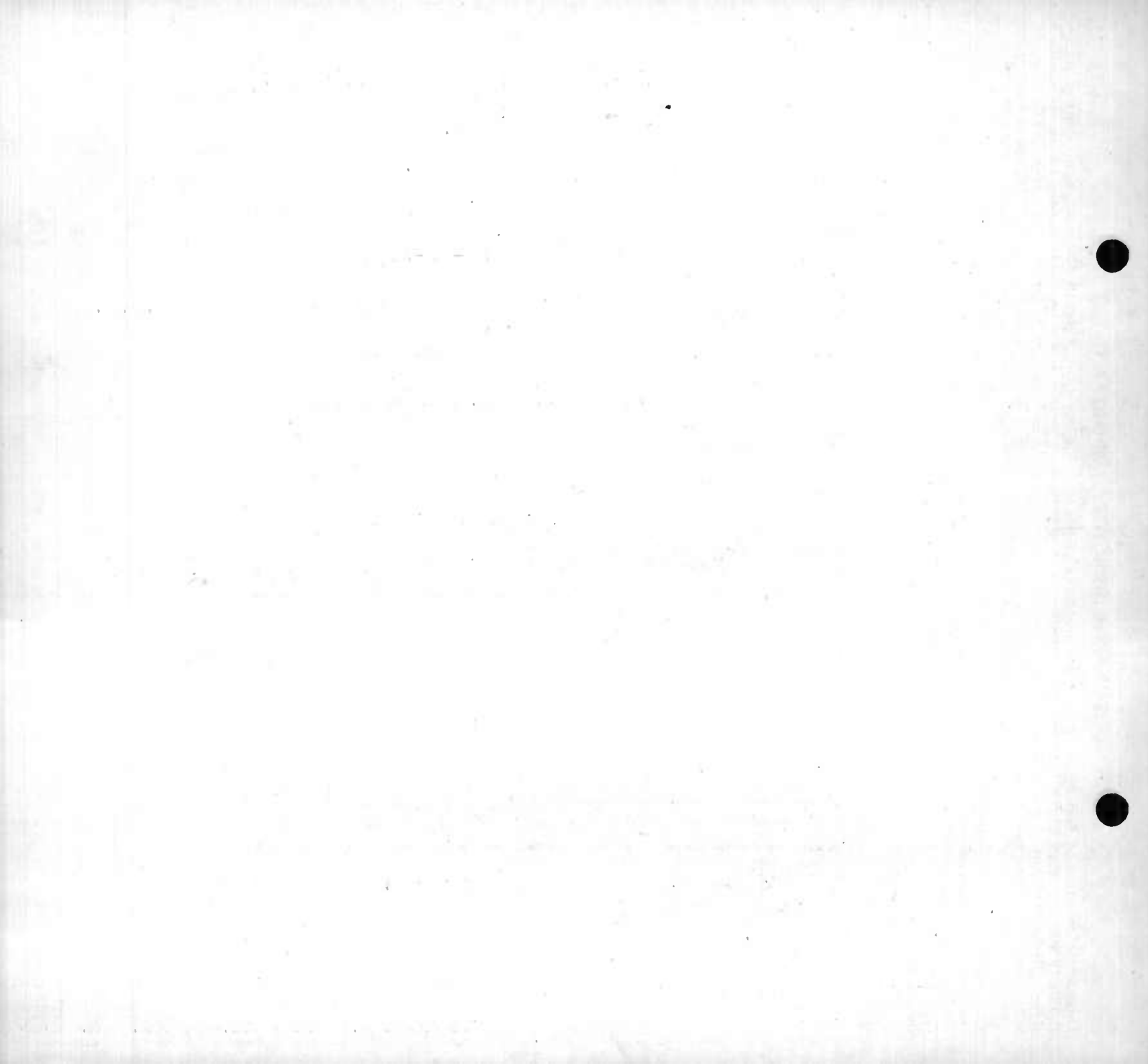
BIRTH NO. 65 3654		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3654	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JOHN S.R. SHANKLIN		APRIL 2, 1965		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE MD.		B. COUNTY	
GOULD NURSING HOME		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		BALTIMORE	
		D. STREET ADDRESS (If rural, give location)		3502 HAMILTON AVENUE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days Hours Min.
MALE	WHITE	WIDOWER	2/24/1879	86	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		INSURANCE		MARYLAND	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JOHN W. SHANKLIN		MAGGIE CROMWELL		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
				MISS MILDRED SHANKLIN SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Generalized Atherosclerosis DUE TO Cardiovascular disease Chronic Cardiac Decompensation		20 years.	
		(B) DUE TO			
		(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Pneumonitis Chronic		6 weeks.	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Aug 19 65 to April 19 65, that (I) (we) last saw the deceased alive on 1 April 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Thomas J Brennan		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 2 April 65	
23C. PHYSICIAN'S NAME (Type) Thomas J Brennan		23D. ADDRESS 5217 Harford Road Balto 14 Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION (City, town or county) (State)		
BURIAL	4/5/65	PROSPECT HILL CEMETERY	BALTIMORE, MARYLAND		
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR ADDRESS JEONARD J. CRUCK, INC., BALTO., MD. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 3655		REGISTERED NO. 65 3655	
M.E. CASE NO. 65 3655				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Anna Koehler</i>				2. DATE AND HOUR OF DEATH <i>April 2, 1965</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>2928 Pinewood Avenue</i>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <i>2707</i>			
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto.</i>			
				D. STREET ADDRESS (If rural, give location) <i>2928 Pinewood Avenue</i>			
5. SEX <i>Female</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>11-21-1892</i>	9. AGE (In years lost birthday) <i>72</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Amoss Shupp</i>				14. MOTHER'S MAIDEN NAME <i>Luccetta</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>188098211</i>		17. INFORMANT <i>Mr. Nevin Koehler</i>		ADDRESS <i>Same</i>	
18. <i>443X-1156-2</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <i>Myocardial degeneration</i> <i>Hypertensive Arteriosclerotic Cardiovascular Disease Grade III c</i> <i>Cardiomegaly</i>				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>6-8 mos.</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Hepatic Metastatic Carcinoma etiol undetd.</i>							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>May 19 56</i> to <i>Apr 19 65</i> , that (I) (we) last saw the deceased alive on <i>March 12, 1965</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>[Signature]</i>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>4/3/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>F.T. KASIK</i>				23D. ADDRESS <i>9005 Harford Rd.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/5/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Buena Vista Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Broadheadville, Pennsylvania</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 6 1965</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor</i>		25C. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc.</i>		ADDRESS <i>Balto., Md. 21214</i>	

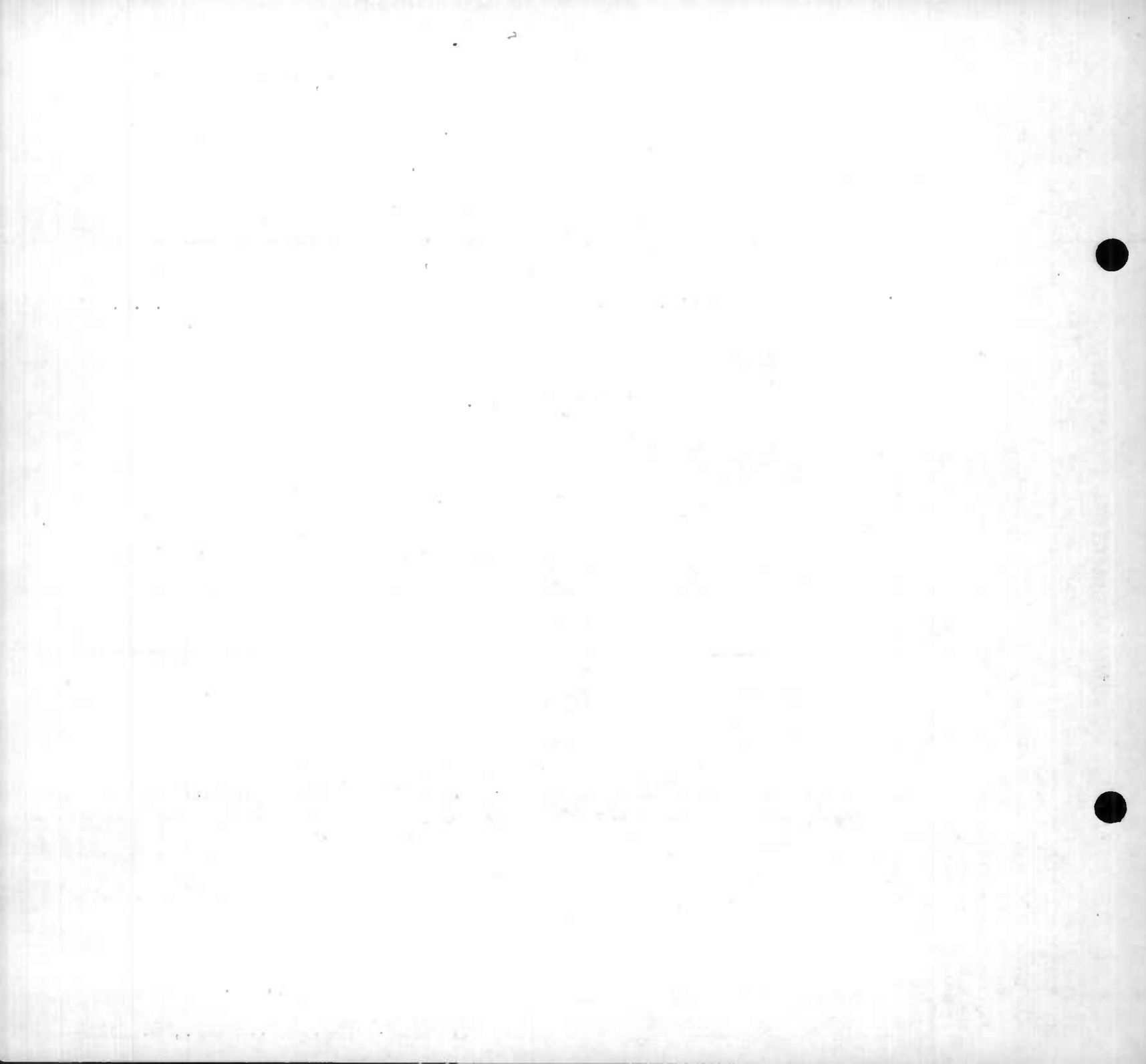




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3656				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3656	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ANDREW KOURLESIS				2. DATE AND HOUR OF DEATH APRIL 3, 1965			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5801 WILLOWTON ROAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. D. STREET ADDRESS (If rural, give location) 5801 WILLOWTON ROAD			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) SINGLE	8. DATE OF BIRTH JULY 9, 1921	9. AGE (In years lost birthday) 43	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10B. KIND OF BUSINESS OR INDUSTRY BALTO. SALESBOOK CO		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANGELO KOURLESIS				14. MOTHER'S MAIDEN NAME STELLA STRATAKOS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213183459		17. INFORMANT MR. STEVE KOURLESIS		ADDRESS SAME	
18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				CAUSE OF DEATH (A) DUE TO Cerebral Coronary Thrombosis (B) DUE TO Hypertensive Cordarone induced heart disease (C) DUE TO Angioid Neurons		INTERVAL BETWEEN ONSET AND DEATH Few minutes 1 yr. year	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from June 15, 1958 to April 3, 1965, that (I) (we) last saw the deceased alive on 4-3-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE William L. Henry				M.D. Attending Phys. <input checked="" type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4-5-65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/6/65		24C. NAME of CEMETERY or CREMATORY GREEK ORTHODOX CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. Stachurski		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214			



T 260

65 3657

BALTIMORE CITY HEALTH DEPARTMENT

65 3657

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)C,  
RALPH TUCKER

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965

11:20 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

6101 Loch Raven Blvd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

Aug. 14, 1890

9. AGE (In years  
last birthday)

74

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

C.P.A.

10B. KIND OF BUSINESS OR INDUSTRY

Self-Employed

11. BIRTHPLACE (State or foreign country)

Michigan

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

? Tucker

14. MOTHER'S MAIDEN NAME

? Dodge

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mrs. Beatrice Tucker

ADDRESS

(Same)

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Cremation

23B. DATE

4/5/65

23C. NAME of CEMETERY or CREMATORY

Greenmount Crematory

23D. LOCATION

(City, town, or county)

Baltimore Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc. Balto. 14 Md.

ADDRESS

WALLLEY & ORRILL

RAILROADS

RAILROADS

RAILROADS

RAILROADS

RAILROADS

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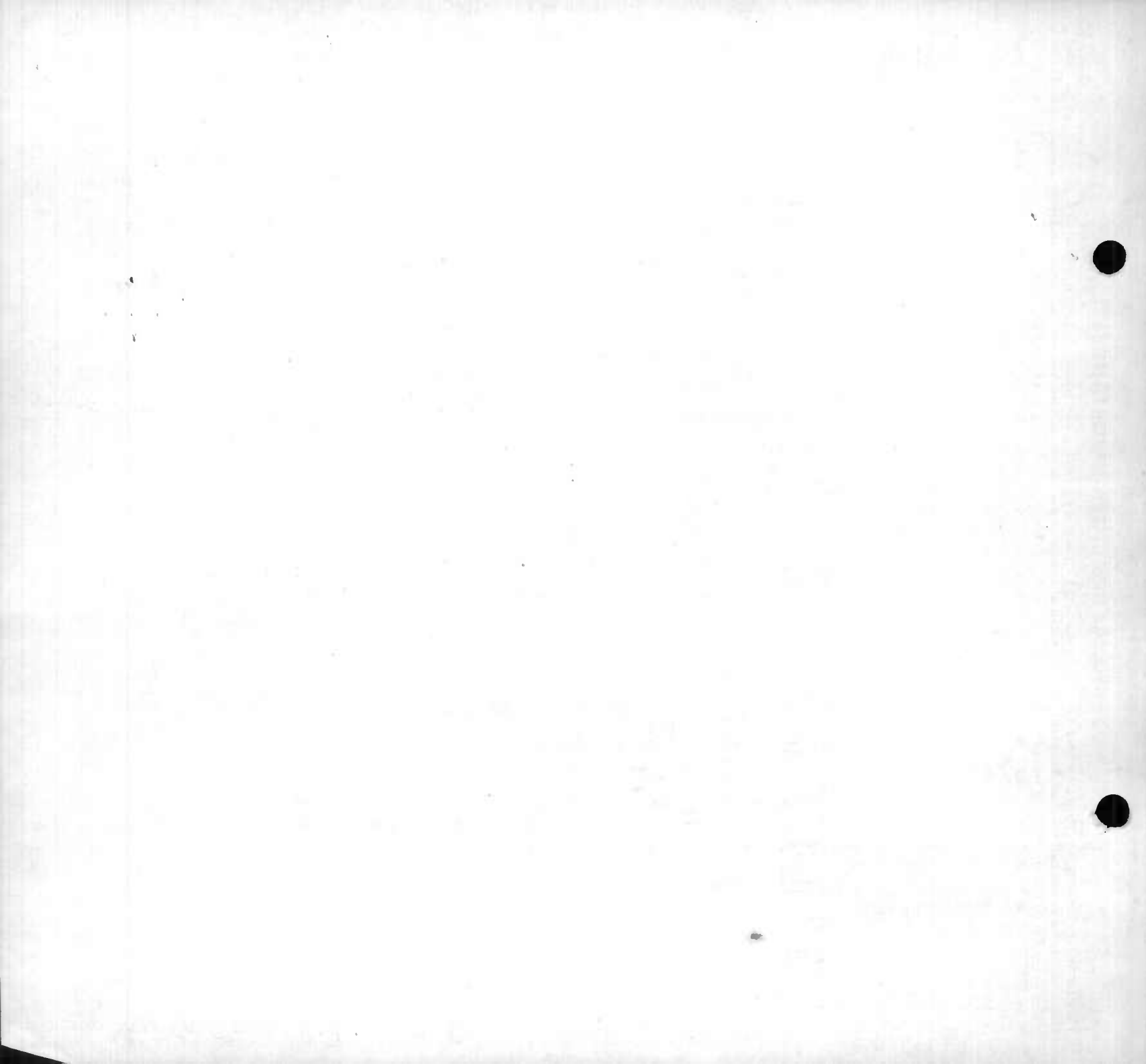
RAILROADS

RAILROADS

FUNERAL DIRECTOR: IMPORTANT

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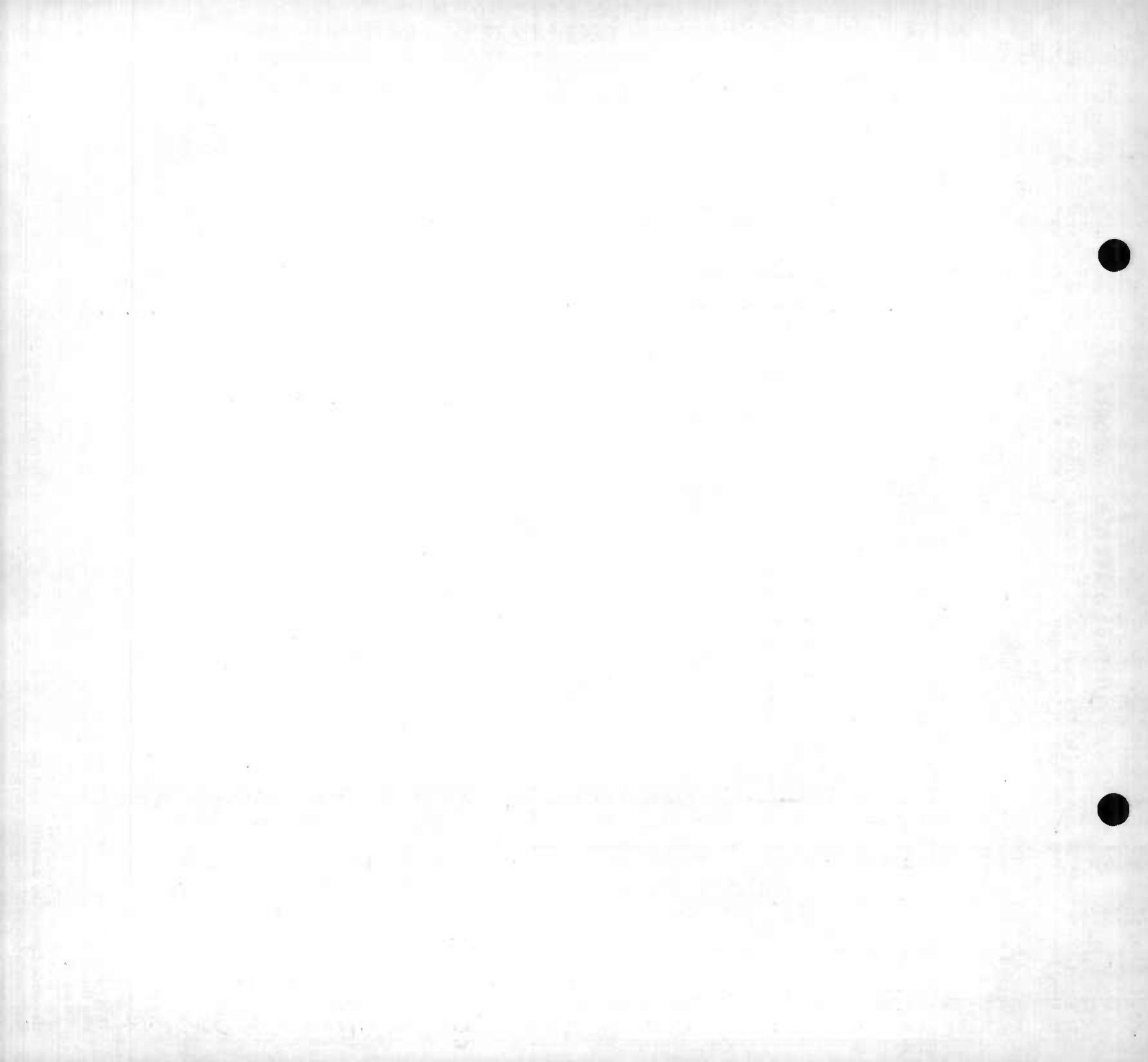
BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. 65 3658		<div style="display: flex; justify-content: space-between;"> <div>CERTIFICATE OF DEATH</div> <div>Registered No. 65 3658</div> </div>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) GRAY, SARAH	
2. DATE AND HOUR OF DEATH 4-4-65 3:10 A.M.		3. PLACE OF DEATH IN BALTIMORE, MARYLAND	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sinai Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 8217 Oakleigh Road #34 6300	
5. SEX F	6. RACE W	7. MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH Mar. 15, 1900
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) 65
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Johnson		14. MOTHER'S MAIDEN NAME ?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Priscilla Struck Box 575 Glenarm ADDRESS
18. 434.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) Pulmonary Edema DUE TO (B) Congestive Heart Failure DUE TO (C) TE	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Fleuro iliac Thrombosis		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) No	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3-30 1965 to 4-4 1965, that (I) (we) lost saw the deceased alive on 4-4 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE Amado P. Tokres		23B. DATE SIGNED 4-4-65	
23C. PHYSICIAN'S NAME (Type) AMADO P. TOKRES		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/7/65	24C. NAME OF CEMETERY OR CREMATORY Moreland Mem Park	24D. LOCATION (City, town, or county) (State) Baltimore, Maryland
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR ADDRESS	
APR 6 1965		Leonard J. Ruck Inc 5305 Harford Rd.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3659		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3659	
M.E. CASE NO.			1. NAME OF DECEASED (Type or Print) <b>DELTA R. Bowes</b>		
2. DATE AND HOUR OF DEATH <b>APRIL - 3, 1965 9:10 P. M.</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>House in the Pines</b>			A. STATE <b>Maryland</b> B. COUNTY <b>2703</b>		
			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
			D. STREET ADDRESS (If rural, give location) <b>3007 Ailsa Avenue</b>		
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>widowed</b>	B. DATE OF BIRTH <b>May 25, 1900</b>	9. AGE (In years last birthday) <b>64</b>	II Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Emp. Monumental</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Printing Co.</b>	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Meredith</b>			14. MOTHER'S MAIDEN NAME <b>?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Mr. Urban P. Bowes 1252 Halstead Rd.</b>
18. <b>170X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) <b>Toxic Absorption</b> DUE TO (B) <b>Carcinoma of Breast &amp; Metastases</b> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>January 26, 1965</b> to <b>April 3, 1965</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>April 1, 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death.					
23A. SIGNATURE <b>Michael J. Dausch</b>				23B. DATE SIGNED <b>April 3, 1965</b>	
23C. PHYSICIAN'S NAME (Type) <b>Michael J. DAUSCH</b>				23D. ADDRESS <b>4636 Balair Road, Baltimore 6 Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/7/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Moreland Mem. Park</b>	
24D. LOCATION (City, town, or County) <b>Baltimore, Maryland</b>		24E. LOCATION (State) <b>(State)</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. J. J. J.</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc 5305 Harford Rd.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3660	
BIRTH NO. 65 3660		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <i>HASHUP MARY K</i>		2. DATE AND HOUR OF DEATH <i>4/14/1965</i> <i>5:35</i> P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND <b>CERTIFICATE CORRECTED 4-9-65</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>903</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>NORTH CHARLES GENERAL HOSP</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
D. STREET ADDRESS <i>2727 N. Charles St</i>		E. STREET ADDRESS (If rural, give location) <i>605 E 35th St.</i>			
5. SEX <i>Fe</i>	6. RACE <i>white</i>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <i>June 10, 1901</i>	9. AGE (In years last birthday) <i>63</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Balti. MD</i>	
13. FATHER'S NAME <i>John (Korniff) Conniff</i>		14. MOTHER'S MAIDEN NAME <i>Emma Lightner</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Patients Chart.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <i>260X I</i>		CAUSE OF DEATH (A) <i>Septic Shock, due to</i> DUE TO (B) <i>Mesenteric thrombosis 2nd</i> DUE TO (C) <i>to Diabetic arteriosclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>No</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>3/27</i> 19 <i>65</i> to <i>4/4</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>4/4</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>George Hebeke</i> M.D.				23B. DATE SIGNED <i>4/14/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>MARION FRIEDMAN</i>		23D. ADDRESS M.D. <i>5211 Harford R. Balto 15 MD</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>4/8/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Gardens of Faith</i>	
24D. LOCATION <i>Baltimore, Maryland</i>		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <i>APR 6 1965</i>		25B. NAME OF REGISTRAR <i>George Hebeke</i>		25C. FUNERAL DIRECTOR <i>Georgio J. Ruck Inc</i>	
		ADDRESS <i>5305 Harford Rd.</i>			

V.S. 153

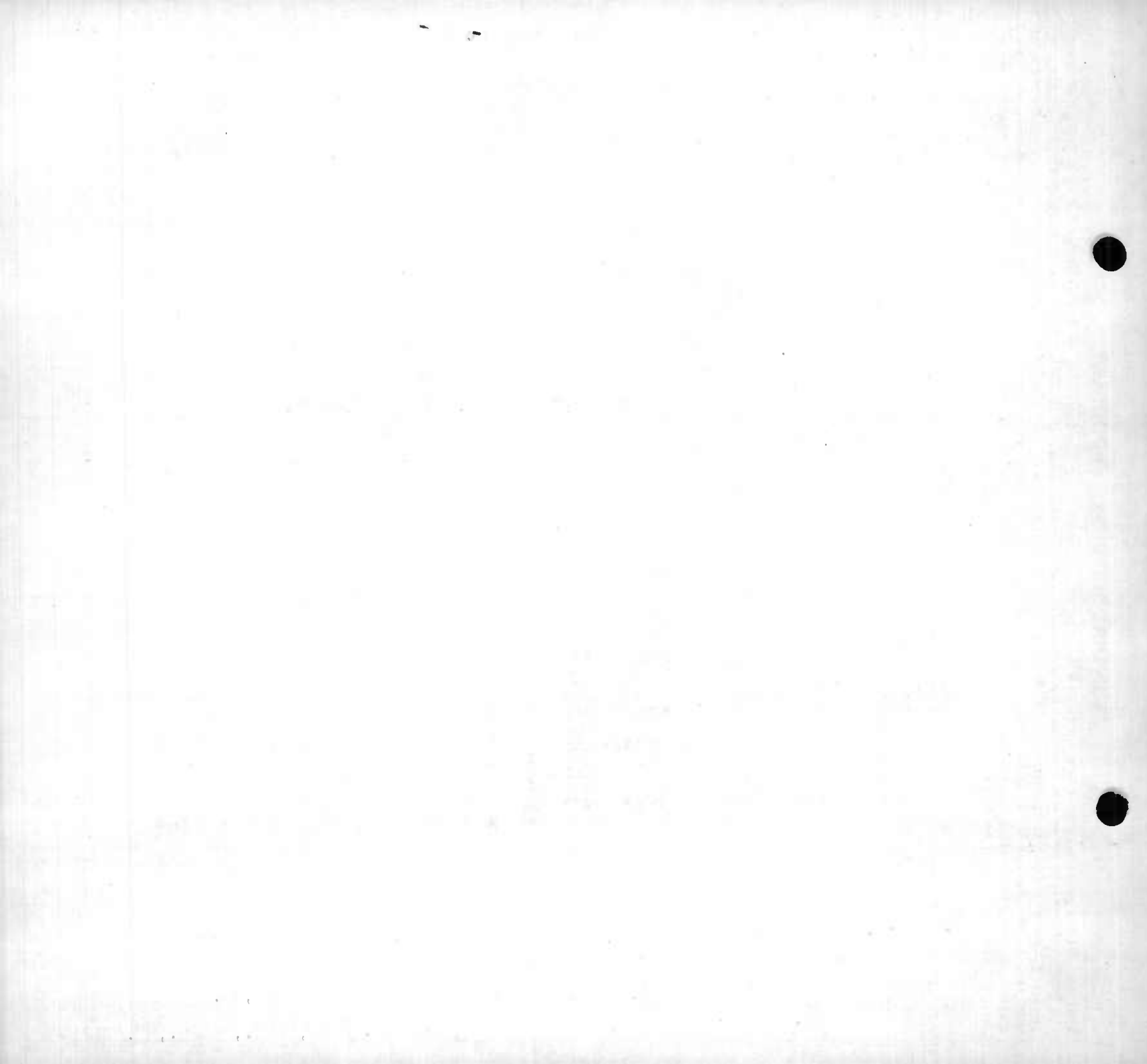
4-9-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

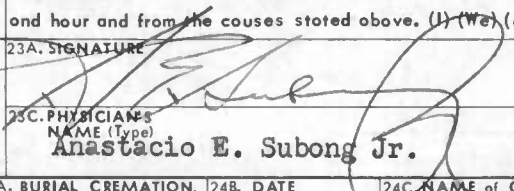
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

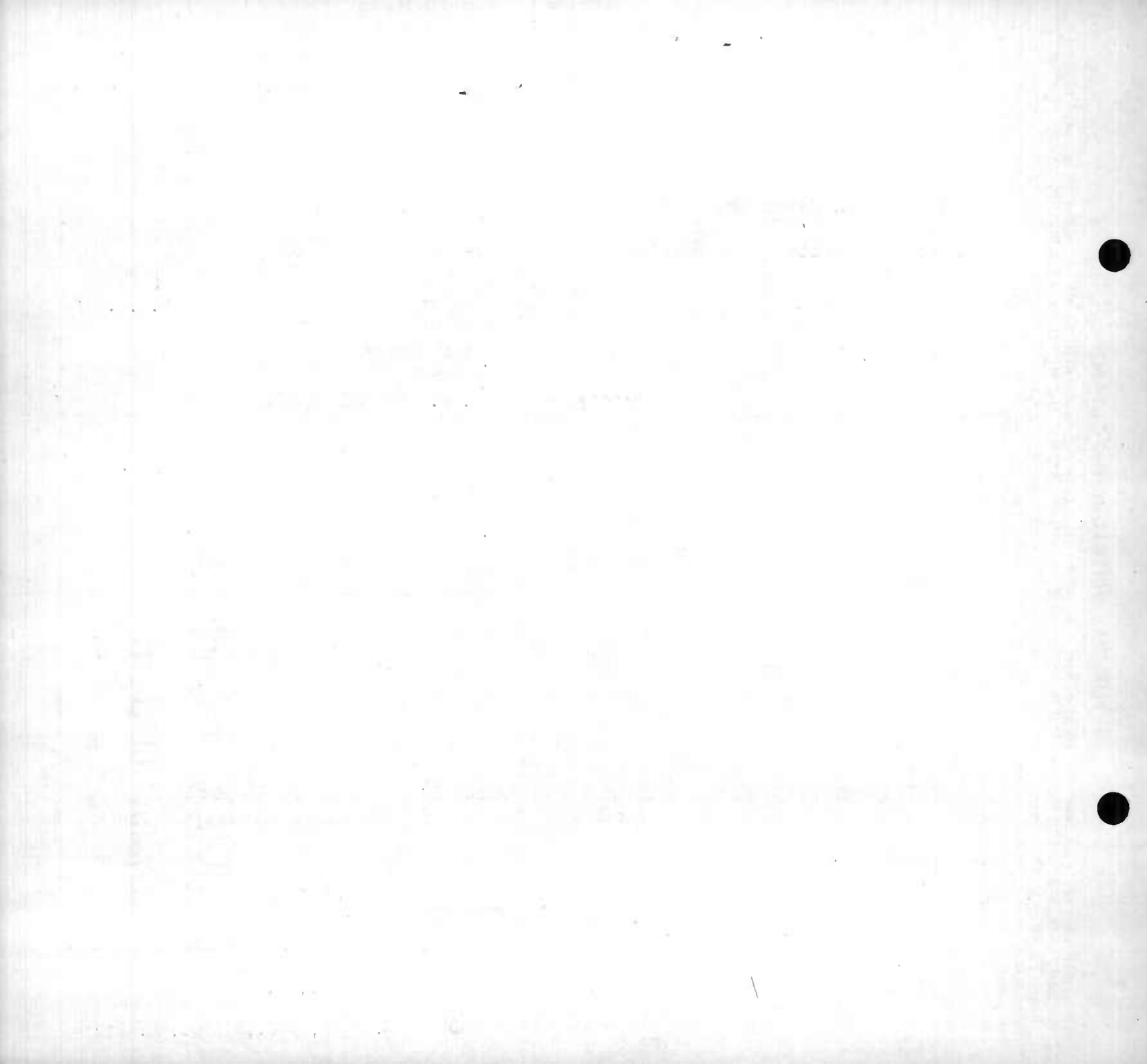
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3661	
BIRTH NO. 65 3661		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) MILDRED IRENE GOEB		2. DATE AND HOUR OF DEATH APRIL 3, 1965, 555 a.m.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 27-09			
FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location) 38 UNIVERSITY HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 1505 LOTHWOOD. LOCHWOOD Rd			
5. SEX F	6. RACE Cau	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH 10/12/97	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME JOSEPH W. HYMAN		14. MOTHER'S MAIDEN NAME LILLIAN STEVENS.			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212364084		17. INFORMANT ADDRESS MRS. MILDRED FARLOW, SAME	
18. 385X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) MYOCARDIAL INFARCTION DUE TO (B) DUE TO (C) ACUTE CHOLECYSTITIS		INTERVAL BETWEEN ONSET AND DEATH MINUTES 2 DAYS.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 4/2/65		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CHOLELITHIASIS ACUTE CHOLECYSTITIS		20A. AUTOPSY? (Yes or No) NO.	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, locality, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/21 19 65 to 4/3 19 65. that (I) (we) last saw the deceased alive on 4/3 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Chris Peter Tountas M.D.		23B. DATE SIGNED 4/3/65.		23C. PHYSICIAN'S NAME (Type) CHRIS PETER TOUNTAS M.D.	
23D. ADDRESS UNIVERSITY HOSPITAL					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/6/65		24C. NAME OF CEMETERY or CREMATORY BALTIMORE CEMETERY	
				24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.	
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. [unclear]		25C. FUNERAL DIRECTOR LEONARD J. RUCK, INC., BALTO., MD. 21214	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. <span style="font-size: 1.5em;">65 3662</span>		Registered No. <span style="font-size: 1.5em;">65 3662</span>	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Wortman, Harry Leo</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 5 1965</span> <span style="float: right;">5.25P M.</span>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">St. Joseph Hospital</span>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">7-01</span> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 21218</span> D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3909 Yolando Rd.</span>			
5. SEX <span style="font-size: 1.2em;">male</span>	6. RACE <span style="font-size: 1.2em;">white</span>	7. MARRIED, NEVER MARRIED <span style="font-size: 1.2em;">WIDOWED, DIVORCED (specify) married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">10-30-06</span>	9. AGE (in years lost birthday) <span style="font-size: 1.2em;">58</span>	If Under 1 Yr. Months Days Hours Min.	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">SELF EMPLOYED</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Supply Parkville Plumbing</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MARYLAND</span>		
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">HARRY L. WORTMAN</span>				
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">NAN MURRAY</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213012275</span>			17. INFORMANT ADDRESS <span style="font-size: 1.2em;">MRS. M. DOROTHY WORTMAN SAME</span>				
18. <span style="font-size: 1.5em;">420.11</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <span style="font-size: 1.2em;">Acute Anterolateral and Diaphragmatic Myocardial Infarction</span>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">no</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 18</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">April 5</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 5</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE 				23B. DATE SIGNED <span style="font-size: 1.2em;">4-5-65</span>			
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Anastacio E. Subong Jr.</span>				23D. ADDRESS M.D. <span style="font-size: 1.2em;">1400 N. Caroline St. Baltimore 21213 Md.</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>		24B. DATE <span style="font-size: 1.2em;">4/9/65</span>		24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">HOLY REDEEMER CEMETERY</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">BALTO., MD.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 6 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">A. E. Subong Jr.</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">LEONARD S. RUCK, INC., BALTO., MD. 21214</span>		ADDRESS	



D-520

65 3663

BALTIMORE CITY HEALTH DEPARTMENT

65 3663

BIRTH NO.		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		Registered No.	
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print)			2. DATE AND HOUR PRONOUNCED DEAD		
FRANK DINIZ			4/1/65 9:05 p. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
38 University Hospital			New Jersey Hudson		
			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)		
			West New York		
			D. STREET ADDRESS (If rural, give location)		
			6201 Blvd. East Ave.		
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. If Under 24 Hrs. Months, Days Hours Min.
male	white	Single	July 21, 1936	28	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country)	
Bus Driver				New Jersey	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Americo Diniz			Elizabeth Benfatti		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
		140-28-3261		Mr. Americo Diniz (Same)	
18. CAUSE OF DEATH			INTERVAL BETWEEN ONSET AND DEATH		
I B. E-819.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			(A) Craniocerebral injury DUE TO  (B) DUE TO  (C) DUE TO		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
2					yes
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
			street		Balto. Washington Expressway 63-00
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour) (Min.) 4 1 65 7:10p		WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		driver who lost control of car and struck bridge	
22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
W.U. Spitz, M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/>		
23A. BURIAL CREMATION, REMOVAL (Specify)			23B. DATE		23C. NAME OF CEMETERY or CREMATORY
Burial			4/7/65.		Holy Name Cemetery
			23D. LOCATION (City, town, or county)		(State)
			Jersey City, New Jersey		
24A. DATE REC'D BY HEALTH DEPT.			24B. NAME OF REGISTRAR		24C. FUNERAL DIRECTOR ADDRESS
APR 6 1965			Robert E. Taylor, M.D.		Richard Horgan, W. New York, New Jersey

N 856 225 000 5 6 6 9



VALLEY BOULEVARD

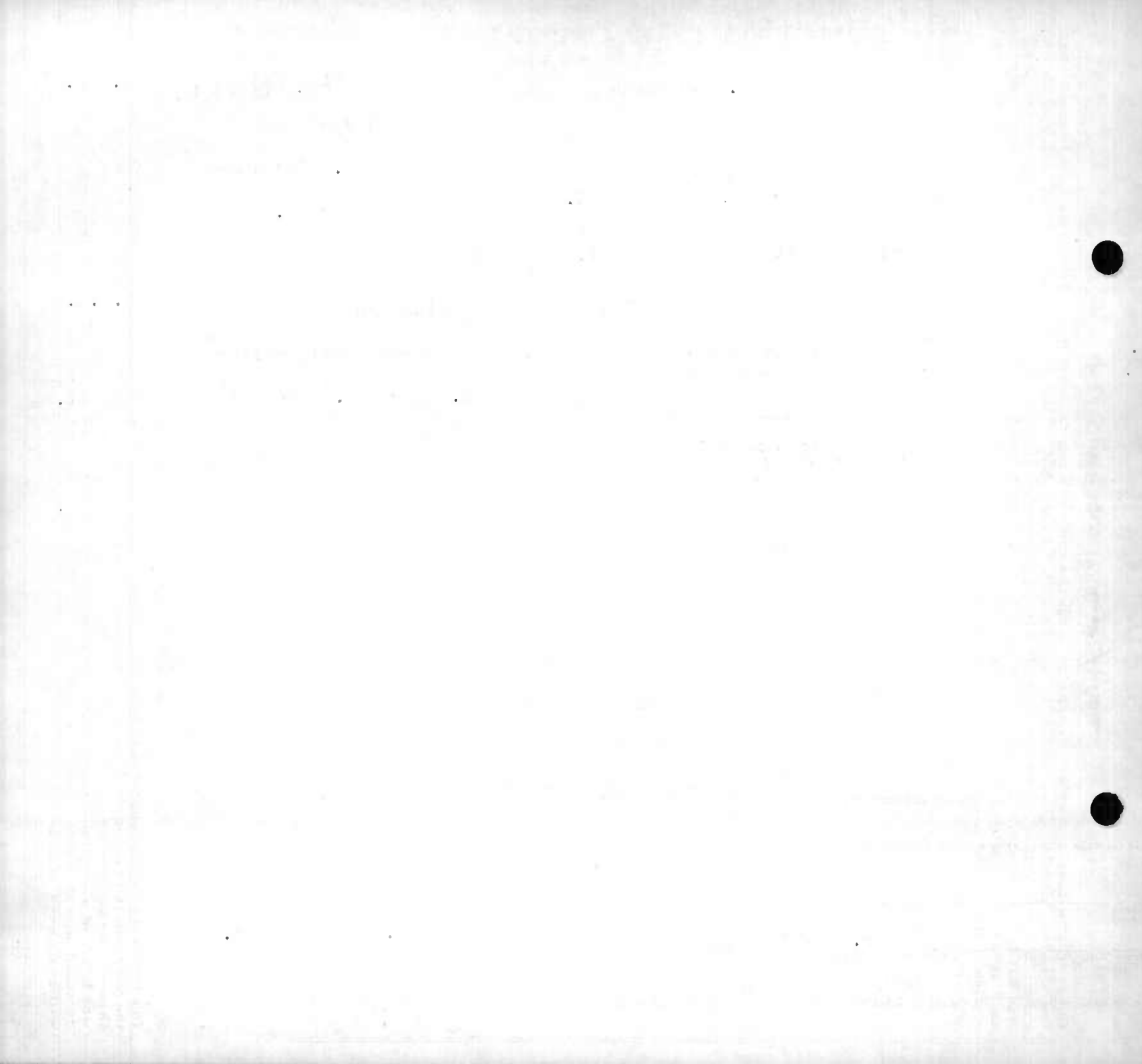
11-11-11



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

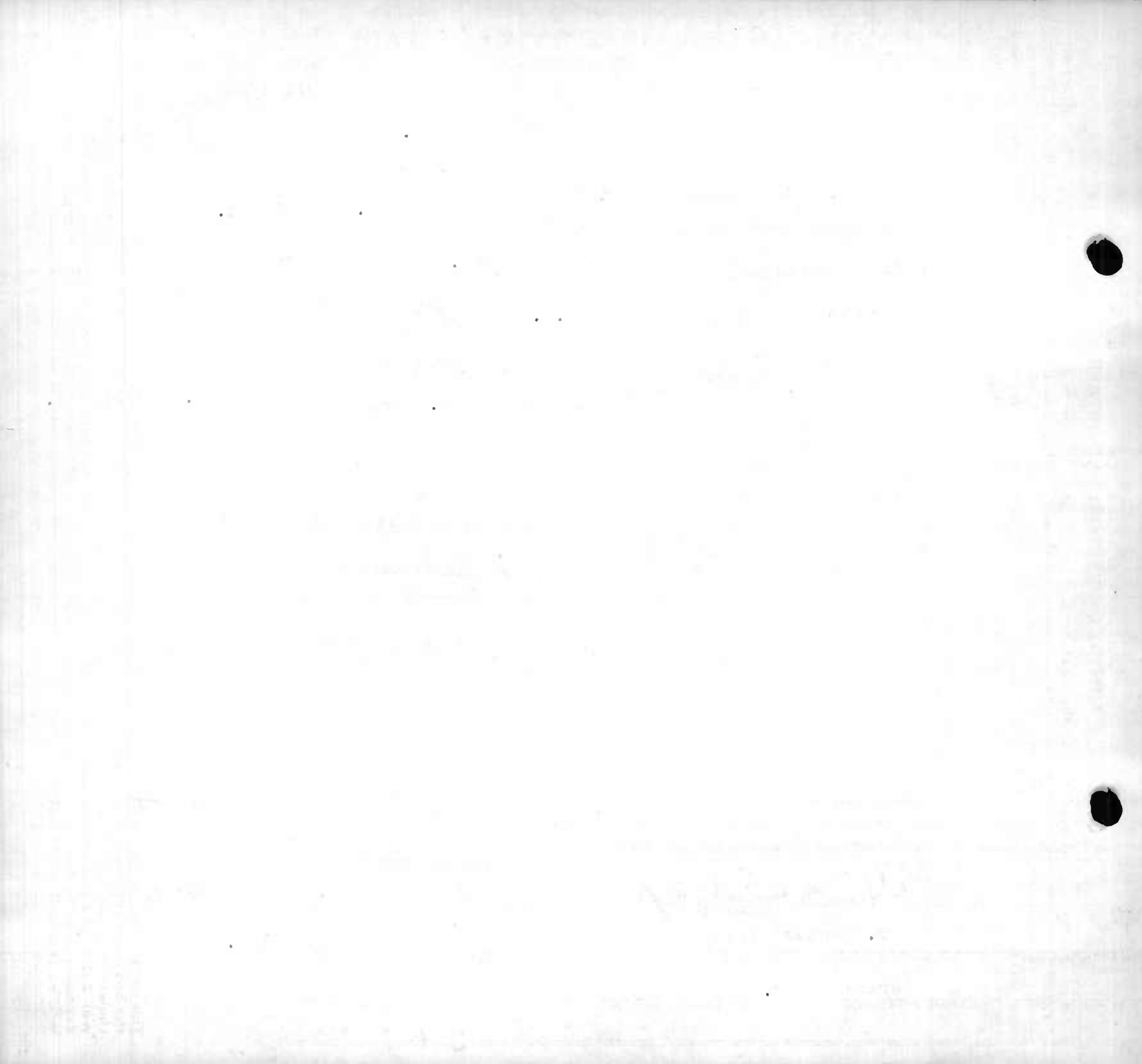
BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 3664		CERTIFICATE OF DEATH		Registered No. 65 3664	
1. NAME OF DECEASED (Type or Print) <b>Mary B. Morgereth</b>						2. DATE AND HOUR OF DEATH <b>April 4/65 5.30P. P.M.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Little Sisters of the Poor I200 Valley St.</b>						4. USUAL RESIDENCE (Where deceased resided before admission) A. STATE <b>MD</b> B. COUNTY <b>W</b> <b>4205 Standood Ave</b>			
						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
						D. STREET ADDRESS (If rural, give location) <b>I200 Valley St.</b>			
5. SEX <b>Female</b>		6. RACE <b>White</b>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>		8. DATE OF BIRTH <b>7/9/1881</b>		9. AGE (In years last birthday) <b>83</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Kilian Koehler</b>						14. MOTHER'S MAIDEN NAME <b>Barbara Waldmueller</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT (Husband) <b>Mr. Herman F. Morgereth</b>		ADDRESS <b>I200 Valley St.</b>	
18. <b>153.81</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slofing the UNDERLYING CONDITION lost.						CAUSE OF DEATH <b>Co of the Colon</b> (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>April 4</b> 19 <b>65</b> , that (I) (we) lost saw the deceased olive on <b>April 4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Stanley Ankudas</b> M.D.						Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4.6.65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Stanley Ankudas</b>				23D. ADDRESS M.D. <b>I802 W. Baltimore St.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/7/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Staley</b>		25C. FUNERAL DIRECTOR <b>Phillip Herwig Sons</b>		ADDRESS <b>2024 Orleans St</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3665				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3665	
M.E. CASE NO.							
1. NAME OF DECEASED (Type or Print) <b>Marvin Jones</b>				2. DATE AND HOUR OF DEATH <b>April 4/65</b> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>				A. STATE <b>Md.</b> B. COUNTY <b>6-03</b>			
(If not in hospital or institution, give street address or location)				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>			
				D. STREET ADDRESS (If rural, give location) <b>429 N. Maderia St.</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>Mar. 22/1894</b>	9. AGE (In years lost birthday) <b>71</b>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Canton R.R.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>John Jones</b>				14. MOTHER'S MAIDEN NAME <b>Sarah Ward</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>705 IO 9198</b>		17. INFORMANT (Wife) <b>Mrs. Dorothy Jones</b>		ADDRESS <b>429 N. Maderia St.</b>	
18. <b>420.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH (A) <b>Coronary Thrombosis</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Arteriosclerotic Heart Disease</b> DUE TO		<b>5 yrs</b>	
				(C) <b>Hypertension</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.				<b>Nephrosclerosis</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>19 61</b> to <b>4-4</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>3-31</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Dr. Hunter Wilson</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4-6-65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Hunter Wilson</b>				23D. ADDRESS M.D. <b>803 Medical Arts Bldg.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4.8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Dr. G. E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Philip Herwig Sons</b>		ADDRESS <b>2024 Orleans St.</b>	



# FUNERAL DIRECTOR: IMPORTANT

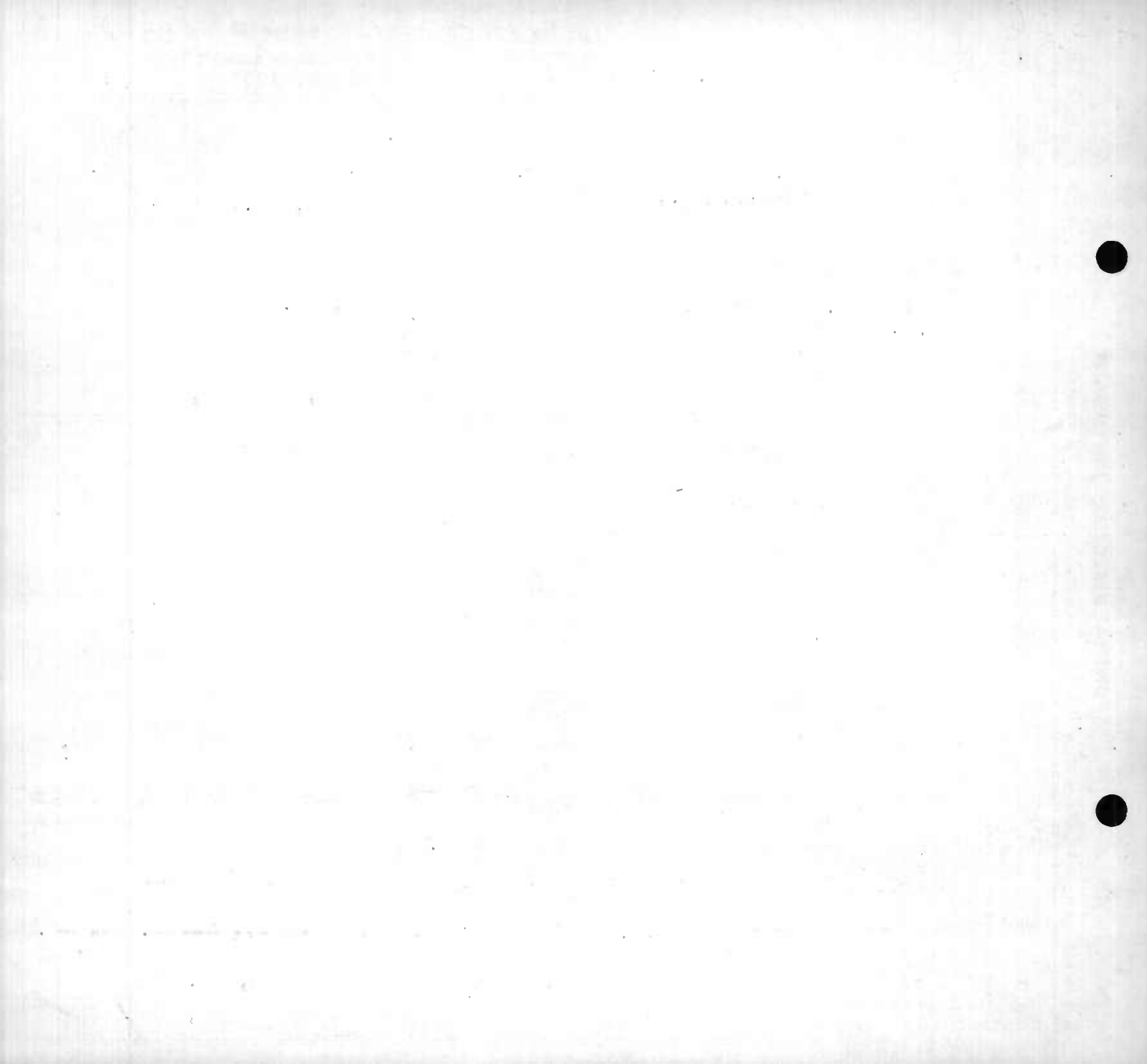
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 3666

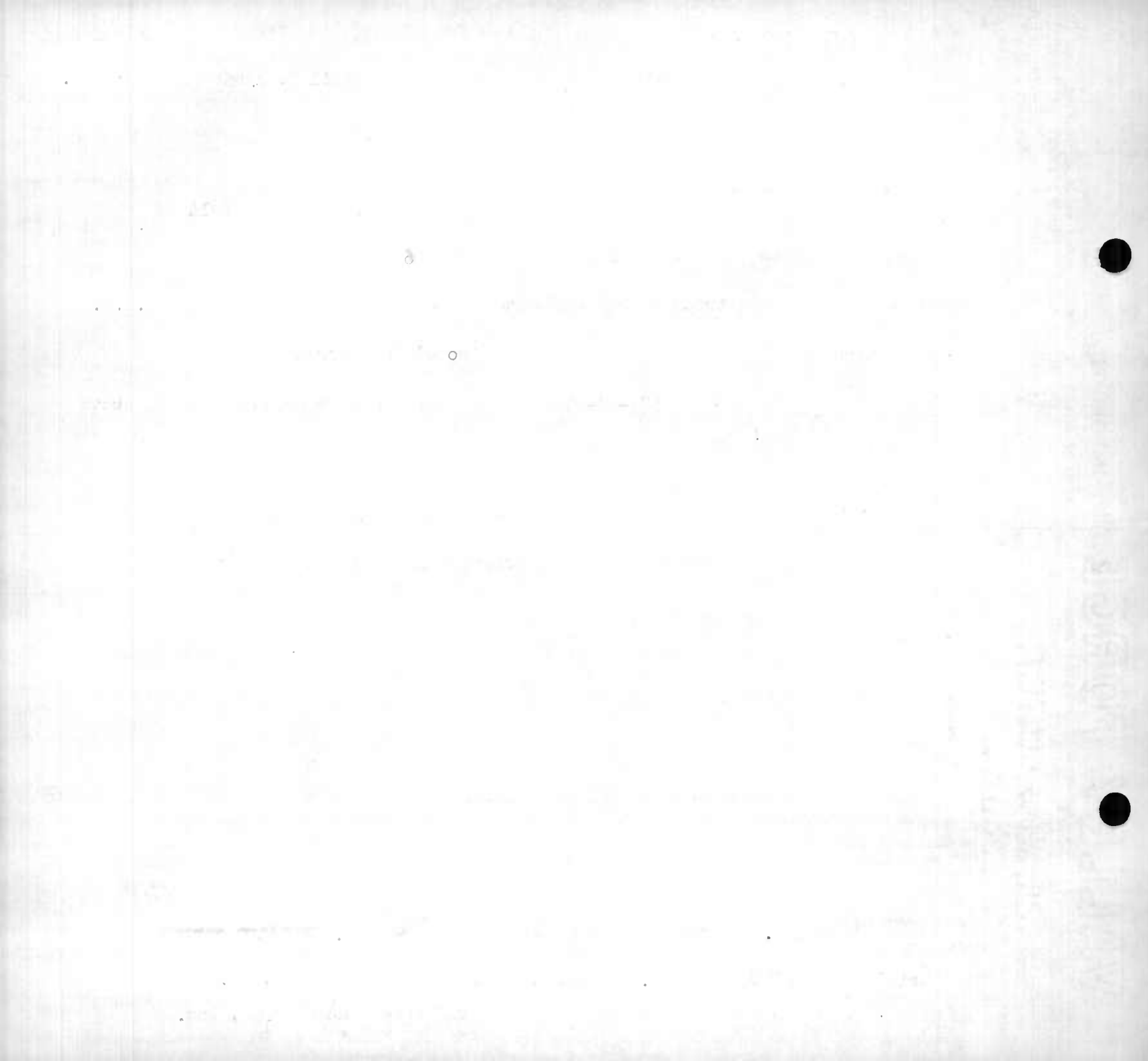
BIRTH NO. M.E. CASE NO. 65 3666		1. NAME OF DECEASED (Type or Print) MARIE A. ANDERS		2. DATE AND HOUR OF DEATH April 2, 1965 10:30 a M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 837 N. Patterson Park Ave. Baltimore, Md., 21205			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Md. B. COUNTY 103 C. CITY OR TOWN (If outside city limits, write RURAL and give township) 837 N. Patterson Park Ave. D. STREET ADDRESS (If rural, give location) Baltimore, Md., 21205		
5. SEX female	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) married	8. DATE OF BIRTH 12/30/13	9. AGE (In years lost birthday) 51	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Label Dept.		10B. KIND OF BUSINESS OR INDUSTRY Frankford Distillery		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Frank Hinkleman			14. MOTHER'S MAIDEN NAME Elizabeth Hinkleman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Raymond Anders, husband, above	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. - SEVERE DEBILITATION			CAUSE OF DEATH MALIGNANT Tumor of the Brain (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Feb 7 1965 to Apr 2 1965, that (I) (we) last saw the deceased alive on Apr. 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Andrew Lemischka M.D.				23B. DATE SIGNED 4/3/65	
23C. PHYSICIAN'S NAME (Type) Andrew Lemischka M.D.		23D. ADDRESS 2608 E. Baltimore St, Balto. 24, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/6/65		24C. NAME of CEMETERY or CREMATORY Baltimore Cemetery	
24D. LOCATION Baltimore, Md.		24E. LOCATION (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Erehms Lane	



# FUNERAL DIRECTOR: IMPORTANT

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BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <span style="font-size: 1.2em;">65 3667</span>	
BIRTH NO. <span style="font-size: 1.2em;">65 3667</span>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO. <span style="font-size: 1.2em;">65 3667</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">GAGNE , GEORGE Louis</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">April 3, 1965</span> <span style="font-size: 1.2em;">9:00 P.</span> M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.2em;">St/ Joseph Hospital</span>		A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">27-01</span>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.2em;">Baltimore 6</span>			
		D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.2em;">3902 Southern Avenue #14</span>			
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <span style="font-size: 1.2em;">Married</span>	8. DATE OF BIRTH <span style="font-size: 1.2em;">6/26/86</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">78</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Carpenter</span>		10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Strecker Body Builders</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.2em;">Simeon Gagne</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Leopoldine Perron</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">579-01-2449 A</span>		17. INFORMANT <span style="font-size: 1.2em;">Eva Gagne (nee Tondreau) wife above</span>	
18. <span style="font-size: 1.2em;">420.01</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) <span style="font-size: 1.2em;">Azotemia</span> DUE TO (B) <span style="font-size: 1.2em;">Congestive Heart Failure</span> DUE TO (C) <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3/16/</span> <span style="font-size: 1.2em;">19 65</span> to <span style="font-size: 1.2em;">4/3</span> <span style="font-size: 1.2em;">19 65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4/3</span> <span style="font-size: 1.2em;">19 65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Manuel A. Gongon</span>				23B. DATE SIGNED <span style="font-size: 1.2em;">4/3/65</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Manuel A. Gongon</span>		23D. ADDRESS <span style="font-size: 1.2em;">1400 N. Caroline Street</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">4/7/65</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">St. Stanislaus Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore, Md.</span>					
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">APR 6 1965</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Stachurski</span>		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Schimunek Funeral Home, Inc. 3331 Brehms Lane #13</span>	
		ADDRESS			





# FUNERAL DIRECTOR: IMPORTANT

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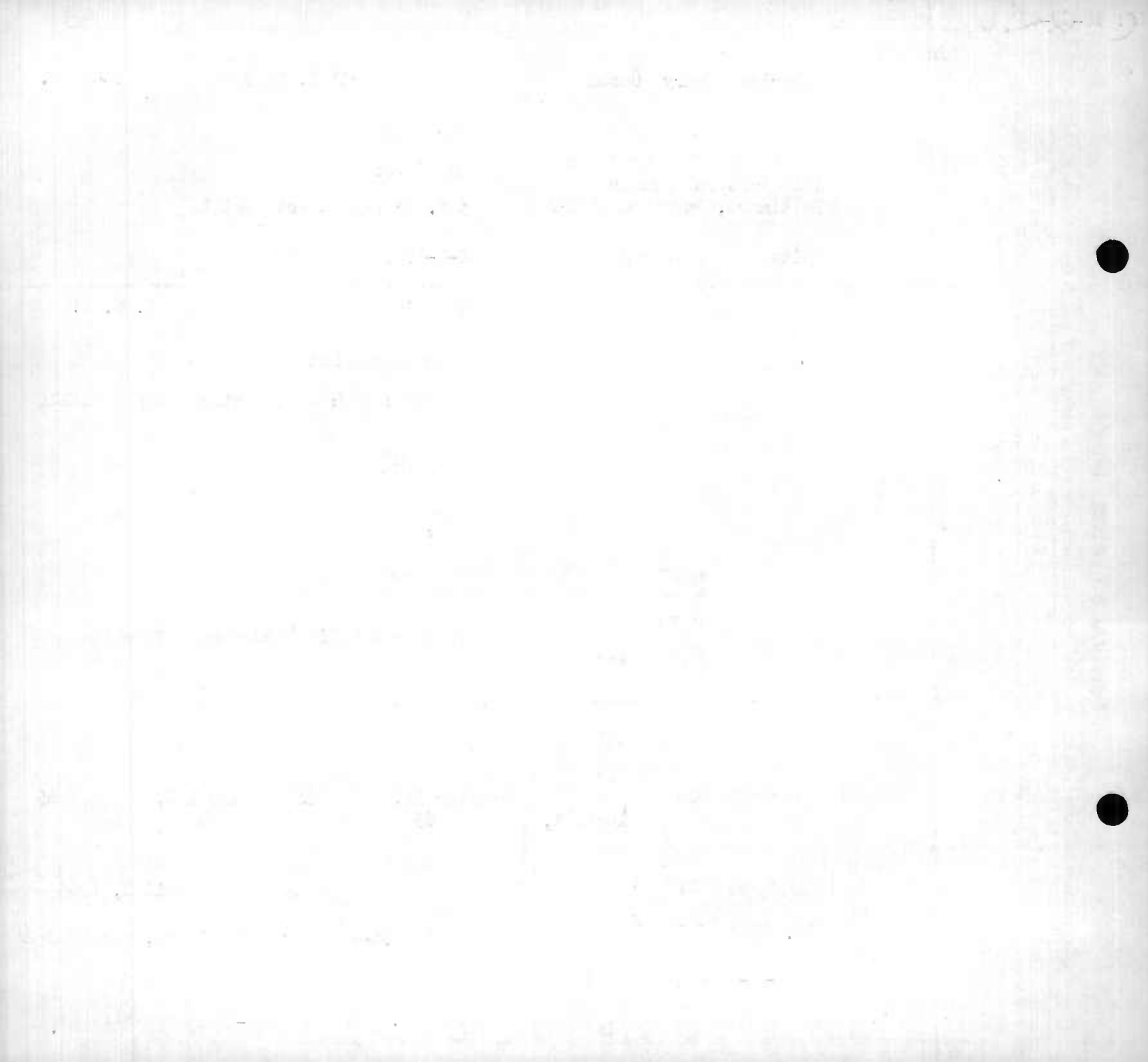
BIRTH NO. 65 3668				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		Registered No. 65 3668	
M.E. CASE NO.				1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
				Vincelli, Mike (MICHELE)		April 2 1965		5.55P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE Maryland		B. COUNTY 302			
St. Joseph Hospital				C. CITY OR TOWN Baltimore #21231		D. STREET ADDRESS (If rural, give location)		242 S. Eden St.	
5. SEX male	6. RACE white	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed	8. DATE OF BIRTH 5-21-95	9. AGE (In years last birthday) 69	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired		Stone Mason Local #1		ITALY		ITALY			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO						MARY CANNETT		649 S. 48th ST	
18. 422.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) Acute Myocardial Insufficiency DUE TO Combined aorto-iliac & femoro-popliteal occlusive vascular disease (C) Generalized Arteriosclerosis					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION 1/31/1965		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Peripheral vascular Insufficiency		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from March 11 19 65 to April 2 19 65, that (I) (we) last saw the deceased alive on April 2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Juan Gan				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED April 2 1965			
23C. PHYSICIAN'S NAME (Type) Juan Gan				23D. ADDRESS M.D. 1100 N. Caroline St Baltimore 21213 Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4-6-65		24C. NAME OF CEMETERY or CREMATORY DAK LAWN CEMETERY		24D. LOCATION (City, town, or county) (State) BALTIMORE MD.			
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965		25B. NAME OF REGISTRAR Robert E. S. S. S.		25C. FUNERAL DIRECTOR WEBER FUNERAL HOME		ADDRESS 5311 EDMONDSON AVE			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3669		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3669	
M.E. CASE NO.			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print) <b>Charles Henry Cason</b>			2. DATE AND HOUR OF DEATH <b>April 1, 1965</b> <b>6:30 P. M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Baltimore City Hospitals</b> <b>4940 Eastern Avenue</b> <b>Baltimore, Maryland #21224</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>26-44</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>5 S. Janney Street #21224</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Divorced</b>	8. DATE OF BIRTH <b>4-6-1907</b>	9. AGE (In years lost birthday) <b>57</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Charles H. Cason</b>			14. MOTHER'S MAIDEN NAME <b>Sally Bostwick</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>RECORDS: BCH: 4940 Eastern Avenue #21224</b>		
18. <b>053.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Septicemia</b>			CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO <b>Thrombo Embolic Phenomena</b>		
19. MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>II</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b> <b>1 Week</b> <b>3 Months</b>		
19A. DATE OF OPERATION <b>2</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>December 14, 19 64</b> to <b>April 1, 19 65</b> , that (I) (we) last saw the deceased alive on <b>April 1, 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard Lane</b>			M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>April 1, 1965</b>
23C. PHYSICIAN'S NAME (Type) <b>Dr. Richard Lane</b>			23D. ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland #24</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4-5-65</b>	24C. NAME of CEMETERY or CREMATORY <b>Wisteria Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Union Point -Georgia</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Safford</b>	25C. FUNERAL DIRECTOR ADDRESS <b>John C. Miller Inc-6415 Belair Rd.</b>		



B 650

BALTIMORE CITY HEALTH DEPARTMENT			
BIRTH NO. <b>65 3670</b>		<b>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		Registered No. <b>65 3670</b>	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR PRONOUNCED DEAD	
<b>MARGUERITE BRYAN</b>		<b>4/1/65 16:45 p. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION  <b>4818 Gilray Dr.</b>		A. STATE <b>Maryland</b>	
		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore 27-03</b>	
		D. STREET ADDRESS (If rural, give location) <b>4818 Gilray Dr.</b>	
5. SEX <b>female</b>	6. RACE <b>white</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>April 19, 1916 48</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>200-07-4923</b>	17. INFORMANT ADDRESS <b>Carroll Bryan - 4818 Gilray Drive</b>
18. CAUSE OF DEATH  I <b>791X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  Bronchopneumonia associated with bilateral pulmonary embolism and marked emphysema			INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>W.U. Spitz, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>4/2/65</b>	
23A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	23B. DATE <b>4-2-65</b>	23C. NAME of CEMETERY or CREMATORY <b>Greenmount Crematorium</b>	23D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>
24A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>	24B. NAME OF REGISTRAR <b>Robert E. Jackson</b>	24C. FUNERAL DIRECTOR ADDRESS <b>John C. Miller Inc-6415 Belair Rd.</b>	

3670

John A. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				BIRTH NO. 65 3671		CERTIFICATE OF DEATH		Registered No. 65 3671	
1. NAME OF DECEASED (Type or Print) <b>Andrew, Ira S.</b>				2. DATE AND HOUR OF DEATH <b>4/2/65 9:45 PM</b>					
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>St. Agnes Hospital Caton &amp; Wilkens Aves. Baltimore, Md. 21229</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Arbutus</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>1006 Leeds Avenue</b>					
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>4-12-04</b>		9. AGE (In years last birthday) <b>60</b>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Hecht Co. (Edm.)</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ira Andrew</b>				14. MOTHER'S MAIDEN NAME <b>Cora Case</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>166-03-2835</b>		17. INFORMANT ADDRESS <b>Mrs. Bertha O. Andrew-1006 Leeds Ave-21229</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>420.11</b>				CAUSE OF DEATH (A) <b>Myocardial infarction</b> DUE TO (B) <b>Coronary artery disease</b> DUE TO (C)				INTERVAL BETWEEN ONSET AND DEATH <b>instantaneous</b>  <b>6 1/2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 23 1945</b> to <b>April 2 1965</b> , that (I) (we) last saw the deceased alive on <b>Feb. 23 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE <b>Kennard Yaffe</b>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>4/3/65</b>			
23C. PHYSICIAN'S NAME (Type) <b>KENNARD YAFFE</b>				23D. ADDRESS <b>5501 Forest Park Ave</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4-6-65</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Hubbard</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Hubbard Funeral Home 4107 Wilkens Ave. (Mr. Skarda)</b>					





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and (b) the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

*[Faint, illegible text covering the majority of the page, likely bleed-through from the reverse side.]*

*[Faint handwritten notes in the bottom left corner, possibly including dates like 1/10/14 and 1/11/14.]*

*[Faint handwritten signature or name in the bottom right area.]*

BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

GEORGE J. PETRLICK

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965

1:05 a M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

St. Agnes Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

Howard

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

~~XXXXXXXXXX~~ Elkridge

D. STREET ADDRESS (If rural, give location)

1906 Railroad Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

10-11-17

9. AGE (in years  
last birthday)

XX 47

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Dry Cleaning

10B. KIND OF BUSINESS OR INDUSTRY

Self-Employed

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Frank J. Petrlik

14. MOTHER'S MAIDEN NAME

Theresa Sima

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

WWII

16. SOCIAL  
SECURITY NO.

217-09-4152

17. INFORMANT ADDRESS

Elkridge, Md. 21227

Mrs. Madeline G. Petrlik-1906 Railroad Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-7-65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cem.

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

E. J. Fickel

24C. FUNERAL DIRECTOR

Howard H. Hubbard-4107 Wilkens Ave-21229

ADDRESS

WALLINGFORD

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				65 3674	
BIRTH NO. 65 3674				CERTIFICATE OF DEATH	
M.E. CASE NO.				Registered No.	
1. NAME OF DECEASED (Type or Print) <b>CARROLL, LEWIS EARL</b>				2. DATE AND HOUR OF DEATH <b>4-2-65</b>   <b>10:00 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>28-04</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>ST. AGNES HOSPITAL WILKENS &amp; CATON AVE. BALTIMORE 29, MD.</b>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
D. STREET ADDRESS (If rural, give location) <b>1118 X PLOVER DRIVE 4616 Manordene Rd-29</b>					
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>2-7-97</b>	9. AGE (In years last birthday) <b>68</b>	If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNKNOWN Steamfitter</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>UNKNOWN Retired</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>JOSEPH CARROLL</b>		
14. MOTHER'S MAIDEN NAME <b>EMMA (UNKNOWN) Cleves</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>214-01-7516</b>			17. INFORMANT ADDRESS <b>ST. AGNES RECORDS, WILKENS &amp; CATON AVE.</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				INTERVAL BETWEEN ONSET AND DEATH <b>1-2 wks</b>	
18. CAUSE OF DEATH (A) <b>Myocardial Infarction with congestive heart failure</b> (B) <b>Ruptured Aneurysm with abscess in lesser sac</b> (C) <b>Probable old tuberculosis, pulmonary</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Probable old tuberculosis, pulmonary</b>					
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 9</b> 19 <b>65</b> to <b>APRIL 2</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>APRIL 2</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Marston A Young</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>MARSTON A YOUNG</b>				23D. ADDRESS M.D. <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/6/1965</b>		24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Wilkins Avenue, Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>			
25B. NAME OF REGISTRAR <b>R. B. E. Fink</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Howard H. Hubbard, 4107 Wilkens Ave. # 29</b>			

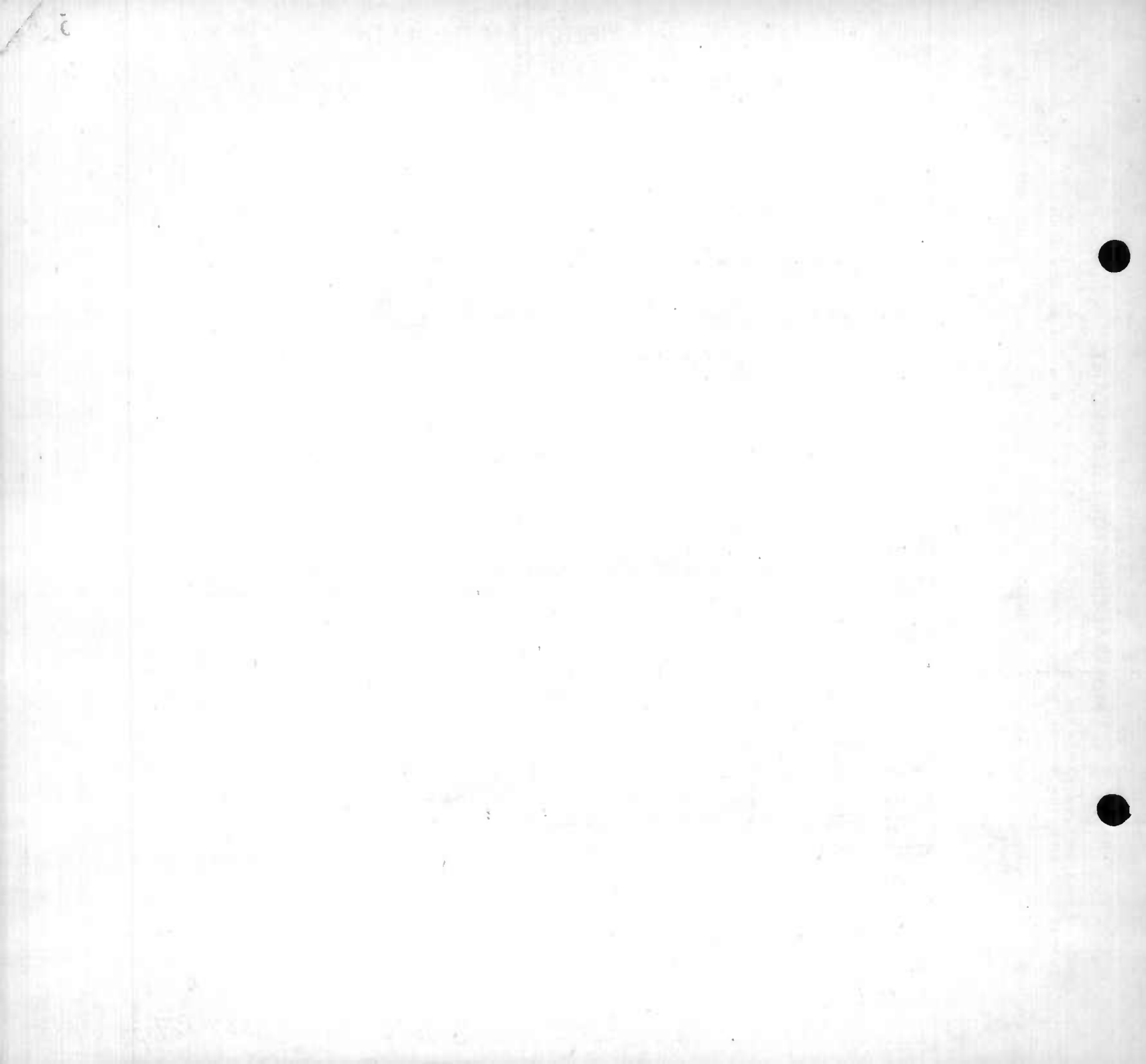


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT										Registered No. <u>65 3675</u>	
BIRTH NO. <u>55 3675</u>		CERTIFICATE OF DEATH									
M.E. CASE NO.		1. NAME OF DECEASED <u>Jesse H. Webster</u>						2. DATE AND HOUR OF DEATH <u>April 1, 1965</u> <u>11 P.</u> M.			
1. NAME OF DECEASED (Type or Print)		3. PLACE OF DEATH IN BALTIMORE, MARYLAND						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>43 South Balto. Gen. Hospital</u>		(If not in hospital or institution, give street address or location)						C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
								D. STREET ADDRESS (If rural, give location) <u>425 Maude Ave.</u>			
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>March 10, 1903</u>		9. AGE (In years last birthday) <u>62</u>		If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Gas &amp; Elec. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Arthur Webster</u>				14. MOTHER'S MAIDEN NAME <u>Leha Webster</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Family</u>		ADDRESS <u>Same</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>420.1 I</u>		CAUSE OF DEATH (A) <u>Acute Myocardial Infarction</u> DUE TO (B) <u>Anterior Myocardial Infarction</u> DUE TO <u>diabetes</u> (C) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>1 year</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.											
19A. DATE OF OPERATION <u>D</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>April</u> 19 <u>65</u> to <u>May</u> 27 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>May</u> 27 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
23A. SIGNATURE <u>Richard Krave</u> M.D.								Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>E. Richard Krave</u> M.D.								23D. ADDRESS <u>705 Redmont Ave. Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4-5-65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Brooklyn, A.A. Co., Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1965</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>McCall</u>		ADDRESS <u>237 Patapsco Ave.</u>					







FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 3676</b>	
BIRTH NO. <b>65 3676</b>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>MILLER, JESSE EUGENE</b>		2. DATE AND HOUR OF DEATH <b>APRIL 1, 1965 10:20 P. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>VETERANS ADMINISTRATION HOSPITAL 3900 LOCH RAVEN BLVD. BALTIMORE, MARYLAND 21218</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>25-42</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b> D. STREET ADDRESS (If rural, give location) <b>2709 WEGWORTH LANE</b>		
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7/7/16</b>	9. AGE (In years lost birthday) <b>48</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MECHANIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>TRUCKING COMPANY</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>WARREN MILLER</b>			14. MOTHER'S MAIDEN NAME <b>SADIE WORKINGER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES 1942 TO 1945</b>		16. SOCIAL SECURITY NO. <b>215 01 4594</b>	17. INFORMANT ADDRESS <b>V.A. HOSPITAL, BALTIMORE., MD. 21218</b>		
18. <b>162.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.) <b>Superior Vena Cava Syndrome</b> (A) DUE TO <b>Antecedent Causes</b> (B) DUE TO <b>5 months</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Empyema</b> (C) _____			INTERVAL BETWEEN ONSET AND DEATH <b>1 months</b> <b>5 months</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that <b>X</b> (this hospital) attended the deceased from <b>FEBRUARY 26 1965</b> to <b>APRIL 1 1965</b> , that <b>X</b> (we) lost saw the deceased alive on <b>APRIL 1 1965</b> and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. ( <b>X</b> (We) (did) <b>X</b> view the body after death.					
23A. SIGNATURE  <b>Robert M. Dr. Swann, M.D.</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS <b>V.A. HOSPITAL, BALTIMORE, MD. 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/6/65</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>AA Co Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>APR 6 1965</b>		25B. NAME OF REGISTRAR <b>E. J. Stokely</b>	25C. FUNERAL DIRECTOR ADDRESS <b>McCully &amp; H 237 Patapsco Ave 25</b>		

10:00 P.

10:00 P. 10:00 P. 10:00 P. 10:00 P. 10:00 P.

10:00 P. 10:00 P. 10:00 P. 10:00 P. 10:00 P.

10:00 P. 10:00 P. 10:00 P. 10:00 P. 10:00 P.

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10:00 P. 10:00 P. 10:00 P. 10:00 P. 10:00 P.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 3677</u>	
BIRTH NO. <u>65 3677</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>GEORGE E. MASON</u>		2. DATE AND HOUR OF DEATH <u>4-3-65</u> <u>3:15 AM</u> M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNION MEMORIAL HOSPITAL</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>			
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>BALTIMORE</u>			
		D. STREET ADDRESS (If rural, give location) <u>3226 ABELL AVE</u>			
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10-6-10</u>	9. AGE (In years last birthday) <u>54</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE MANAGER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>REFRIGERATION</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>WILLIAM B MASON</u>		14. MOTHER'S MAIDEN NAME <u>BERTH A. LINDEMAN</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>UNK NO</u>		16. SOCIAL SECURITY NO. <u>214-01-1717</u>		17. INFORMANT <u>CHART</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>163X I</u>		CAUSE OF DEATH (A) <u>CARCINOMA OF @ LUNG</u> DUE TO (B) _____ DUE TO (C) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 MONTHS</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>13-31-65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>@ LUNG TUMOR</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3-19-</u> 19 <u>65</u> to <u>4-3-</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4-3-</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>R. Thompson</u>				23B. DATE SIGNED <u>4-3-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>ROBERT C. THOMPSON</u>				23D. ADDRESS M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>4/5/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>BALTIMORE CEMETERY</u>	
24D. LOCATION (City, town, or county) (State) <u>BALTIMORE MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>APR 6 1965</u>		25B. NAME OF REGISTRAR <u>APR 5 1965</u>		25C. FUNERAL DIRECTOR <u>ULRICH FUNERAL HOME 4210 BELAIR RD</u>	



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN C. BATZE JR.

2. DATE AND HOUR PRONOUNCED DEAD

4/2/65

2:03 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

43 South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

H. A

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

407 Seward Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Aug 26, 1941

9. AGE (In years  
last birthday)

23

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Clerk

10B. KIND OF BUSINESS OR INDUSTRY

W. MD. RR

11. BIRTHPLACE (State or foreign country)

MD

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John C Batze Sr

14. MOTHER'S MAIDEN NAME

Louis Wagner

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Family

ADDRESS

Same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Severe craniocerebral injury  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

Hanover St.

21D TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 2 65 1:45 a.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒21F. HOW DID INJURY OCCUR? passenger in car  
which struck pole

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐CHIEF MEDICAL EXAMINER ☐

DATE SIGNED

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

4/2/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-5-65

23C. NAME of CEMETERY or CREMATORY

Green Haven Cem

23D. LOCATION

(City, town, or county)

Green Haven MD.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 6 1965

24B. NAME OF REGISTRAR

Werner U. Spitz, M.D.

24C. FUNERAL DIRECTOR

McCally Funeral Home - 2377 Park Ave

ADDRESS

VALLEY BOXC

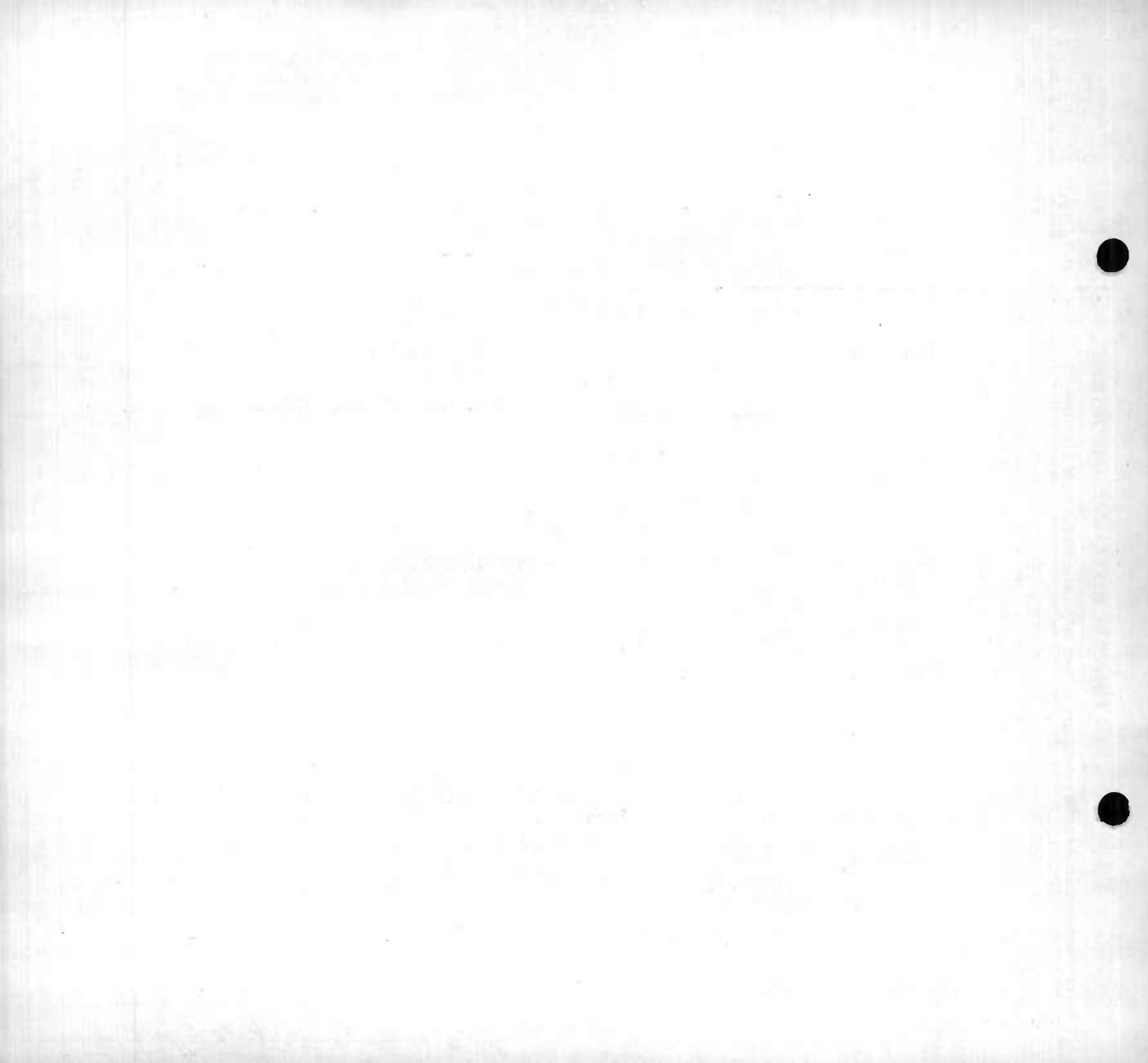
PRODUCTION

1972

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 65 3679					CERTIFICATE OF DEATH					Registered No. 65 3679				
M.E. CASE NO. 65 3679					1. NAME OF DECEASED (Type or Print) GENN, ANTONIA					2. DATE AND HOUR OF DEATH April 4, 1965 5:30 A M.				
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					5. CITY OR TOWN (If outside city limits, write RURAL and give township)				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)					A. STATE Maryland					B. COUNTY 27-05				
St. Joseph Hospital					Baltimore					1234				
6. STREET ADDRESS (If rural, give location)					7602 Daniels Avenue -									
5. SEX Female		6. RACE White		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed		8. DATE OF BIRTH 2-9-82		9. AGE (In years lost birthday) 83		10. Under 1 Yr. Months: Days: Hours: Min.		11. Under 24 Hrs. Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker					10B. KIND OF BUSINESS OR INDUSTRY Own home					11. BIRTHPLACE (State or foreign, country) Yugoslavia				
12. CITIZEN OF WHAT COUNTRY?					13. FATHER'S NAME John Schattel					14. MOTHER'S MAIDEN NAME Magdaline ?				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No					16. SOCIAL SECURITY NO.					17. INFORMANT ADDRESS Mrs. Marie Herzog 3119 McElderry St.				
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)					CAUSE OF DEATH (A) Pulmonary Embolism DUE TO (B) Uremia DUE TO (C) Chronic Cholecystitis with choledocholithiasis					INTERVAL BETWEEN ONSET AND DEATH				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.														
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.														
19A. DATE OF OPERATION April 1, 1965					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystectomy					20A. AUTOPSY? (Yes or No) None				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from March 31, 1965 to April 4, 1965, that (I) (we) lost saw the deceased alive on April 4, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
23A. SIGNATURE Salvador Marse M.D.										23B. DATE SIGNED April 4, 1965				
23C. PHYSICIAN'S NAME (Type) Salvador Marse M.D.										23D. ADDRESS 1400 N. Caroline Street - 21213				
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 4/7/65		24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery			24D. LOCATION (City, town, or county) (State) Parkville, Md.						
25A. DATE REC'D BY HEALTH DEPT. APR 6 1965					25B. NAME OF REGISTRAR Robert E. Taylor					25C. FUNERAL DIRECTOR Address				

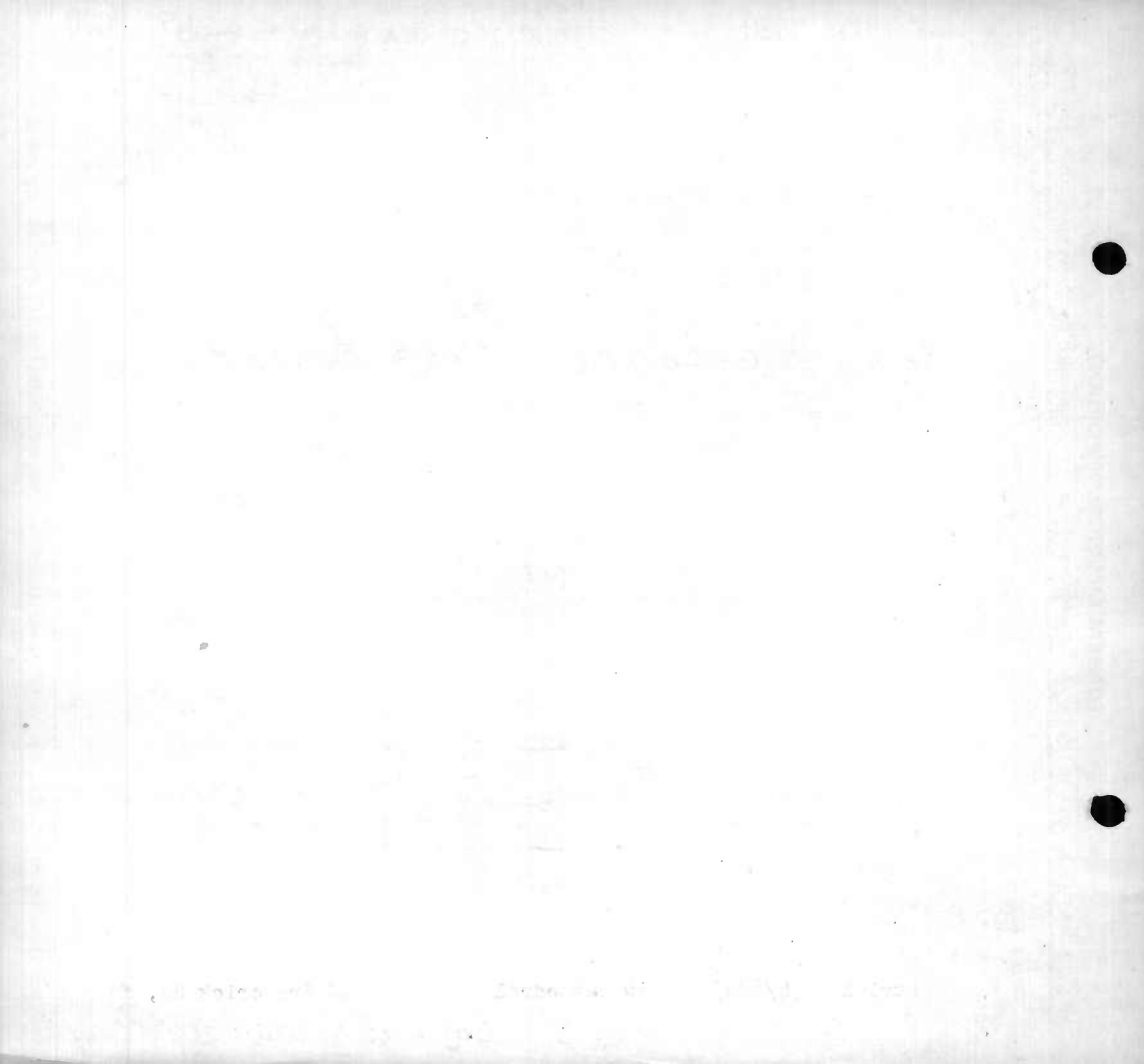




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

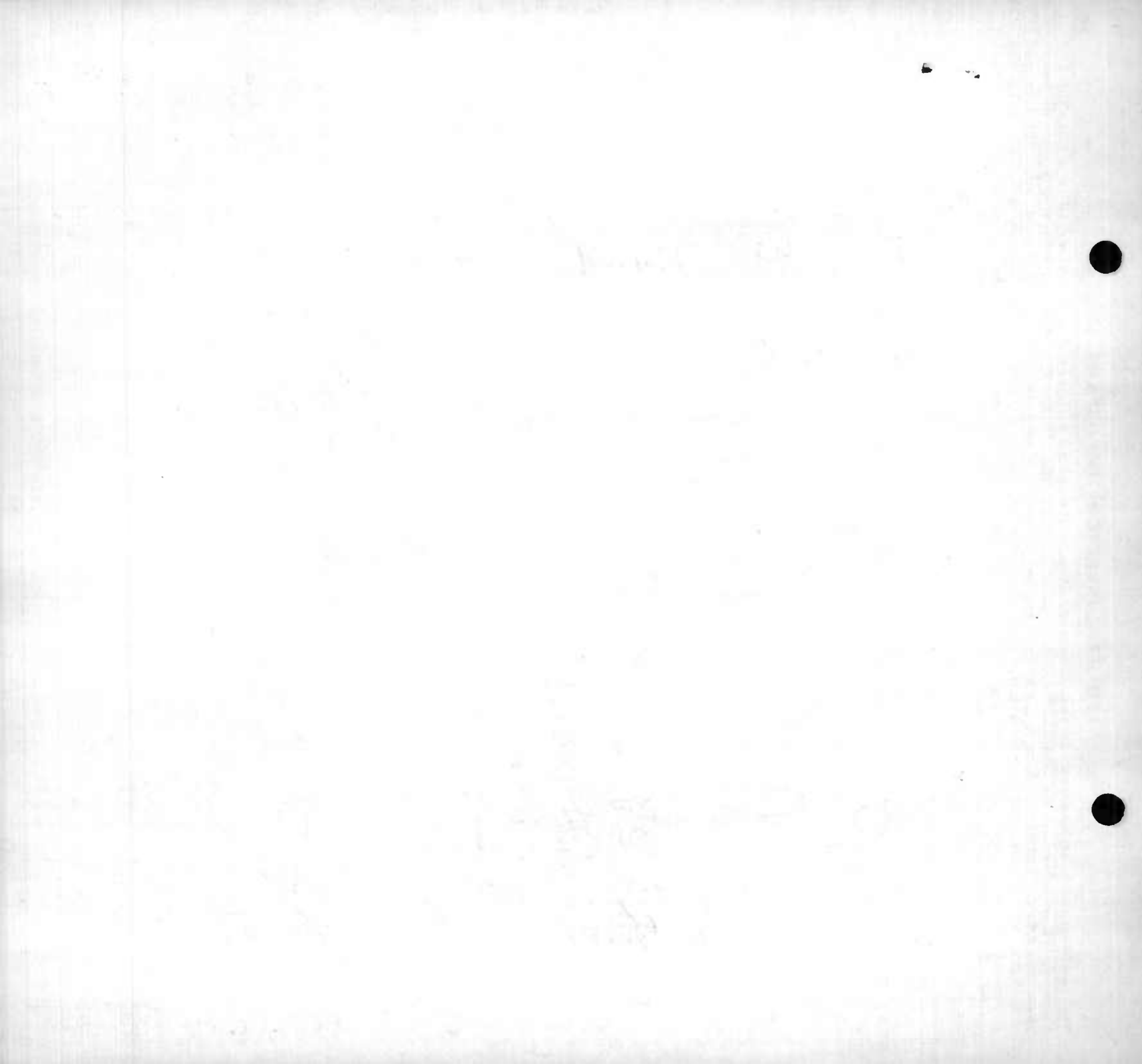
BIRTH NO. 65 3680		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3680	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>STUART A. GALLAGHER</b>		2. DATE AND HOUR OF DEATH <b>4/5/65 4:30 P.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>13-06</b> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b> D. STREET ADDRESS (If rural, give location) <b>3621 ROLAND AVE.</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>1/17/05</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>BARTENDER</b>		11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JAMES S. GALLAGHER</b>		14. MOTHER'S MAIDEN NAME <b>CORA BENDER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>203-10-8768</b>		17. INFORMANT <b>EILEEN R. GALLAGHER</b> ADDRESS <b>SAME</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.1 I</b>		CAUSE OF DEATH (A) <b>PULMONARY EDEMA</b> DUE TO (B) <b>Myocardial infarction</b> DUE TO (C) <b>ASHD</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>40 hours</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (B) (this hospital) attended the deceased from <b>4/5</b> 19 <b>65</b> to <b>4/5</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>4/5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William N. Bennett</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/5/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>William N. BENNETT</b>		23D. ADDRESS <b>Union Memorial Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/8/65</b>		24C. NAME of CEMETERY or CREMATORY <b>New Cathedral</b>	
24D. LOCATION (City, town, or county) (State) <b>Old Frederick Rd, Md</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>Christopher Donovan</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

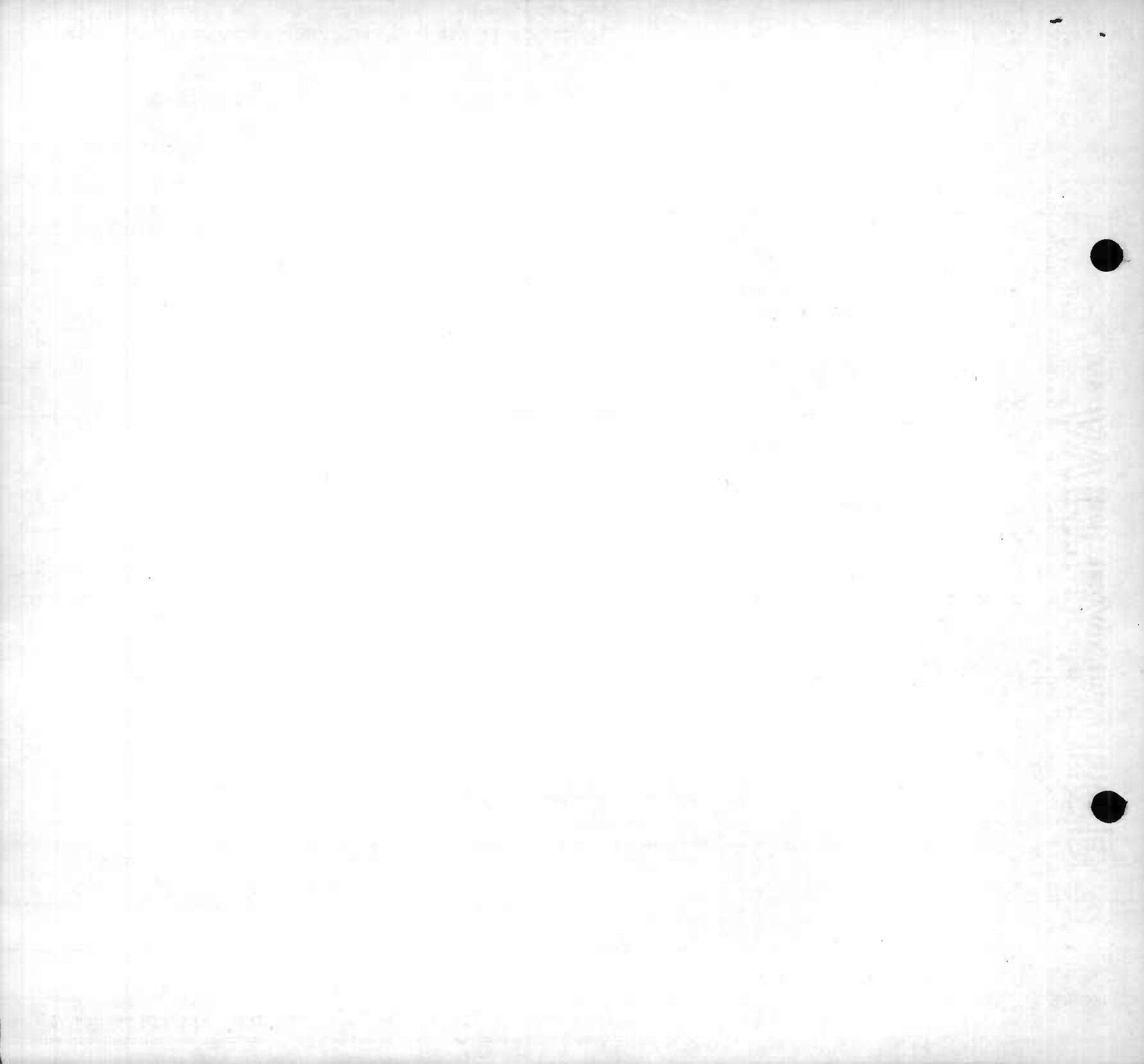
BIRTH NO. 65 3681				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3681	
M.E. CASE NO. 65 3681				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>GERSHEW, SONIA</i>				2. DATE AND HOUR OF DEATH <i>APRIL 3, 1965 849 P.M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Senai Hospital</i>		(If not in hospital or institution, give street address or location)		A. STATE <i>Maryland</i>		B. COUNTY <i>27-20</i>	
				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>			
				D. STREET ADDRESS (If rural, give location) <i>6316 Greenspring Ave.</i>			
5. SEX <i>FEMALE</i>	6. RACE <i>White</i>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Married</i>	8. DATE OF BIRTH <i>4-2-28</i>	9. AGE (In years last birthday) <i>37</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel Goffe</i>				14. MOTHER'S MAIDEN NAME <i>Illie Snyder</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Sidney Ashkenasy</i>		ADDRESS	
18. <i>199.2 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) <i>Circled Prescribed Tumor</i> DUE TO  (B) DUE TO (C) <i>Circled Prescribed Tumor</i>		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <i>Dec 1964</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Circled Prescribed Tumor</i>		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>3/26</i> 19 <i>65</i> to <i>4/3</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4/3</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Philip H. Huff</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>4/3/65</i>	
23C. PHYSICIAN'S NAME (Type) <i>Philip H. Huff</i>				23D. ADDRESS <i>Senai Hospital</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>4/5/65</i>		24C. NAME of CEMETERY or CREMATORY <i>CHIZUK AMINO (ARLINGTON)</i>		24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 7 1965</i>		25B. NAME OF REGISTRAR <i>R. Gabe. Sabin</i>		25C. FUNERAL DIRECTOR <i>SOB LEVINSON &amp; BROS. INC.</i>			
				ADDRESS <i>6010 REISTERSTOWN RD</i>			



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3682		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3682	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) MYERS ZELDA B		2. DATE AND HOUR OF DEATH 4/2/65 1:25 P. M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 13-01			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 48 MARYLAND GENERAL HOSP. 827 LINDEN AVE. BALTIMORE 1, MD.		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE, 17, D. STREET ADDRESS (If rural, give location) 2425 Euton Place			
5. SEX FEMALE	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 8/8/80	9. AGE (In years last birthday) 84	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) POLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME HERSCHEL BLUMENSTEIN		14. MOTHER'S MAIDEN NAME MARIAN BALINSKY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS MARYLAND GEN. HOSP. 827 LINDEN AVE.	
18. 334X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) CEREBRAL VASCULAR DISEASE DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/26 19 65 to 4/2 19 65, that (I) (we) lost saw the deceased alive on 4/2 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Pietro Pietrucci		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/2/65	
23C. PHYSICIAN'S NAME (Type) PIETRUCCI PIETRO		M.D. MARYLAND GENERAL HOSP.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 4/4/65		24C. NAME of CEMETERY or CREMATORY RUDOMER VEREIN	
24D. LOCATION ROSEDALE		24E. LOCATION (City, town, or county) (State) MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. APR 7 1965		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD	



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3683				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3683	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Morris Williams		April 1, 1965 2:10 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
44 Union Memorial Hospital Baltimore				Maryland 27-19			
C. CITY OR TOWN (If outside city limits, write RURAL and give township)				D. STREET ADDRESS (If rural, give location)			
44				4001 Primrose Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days		10. If Under 24 Hrs. Min.
Male	White	Married	October, 1910	34			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Real Estate		Proprietor		Baltimore, Md.		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Abraham Williams				Fannie?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Mrs. Sarah Williams		4001 Primrose Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		10 years +	
ANTECEDENT CAUSES				(B) DUE TO			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
0							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from November 19 1964 to March 23 1965 that (I) (we) last saw the deceased alive on March 23 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
Joseph Shear						4/2/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOSEPH SHEAR				6715 Park Heights Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/2/65		Ohel Yakov		Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 7 1965		Robert E. Taylor		Sal Leonard & Sons Inc		6000 East Rd	

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Handwritten text, possibly a signature or name, appearing upside down.

Handwritten text, possibly a signature or name, appearing upside down.

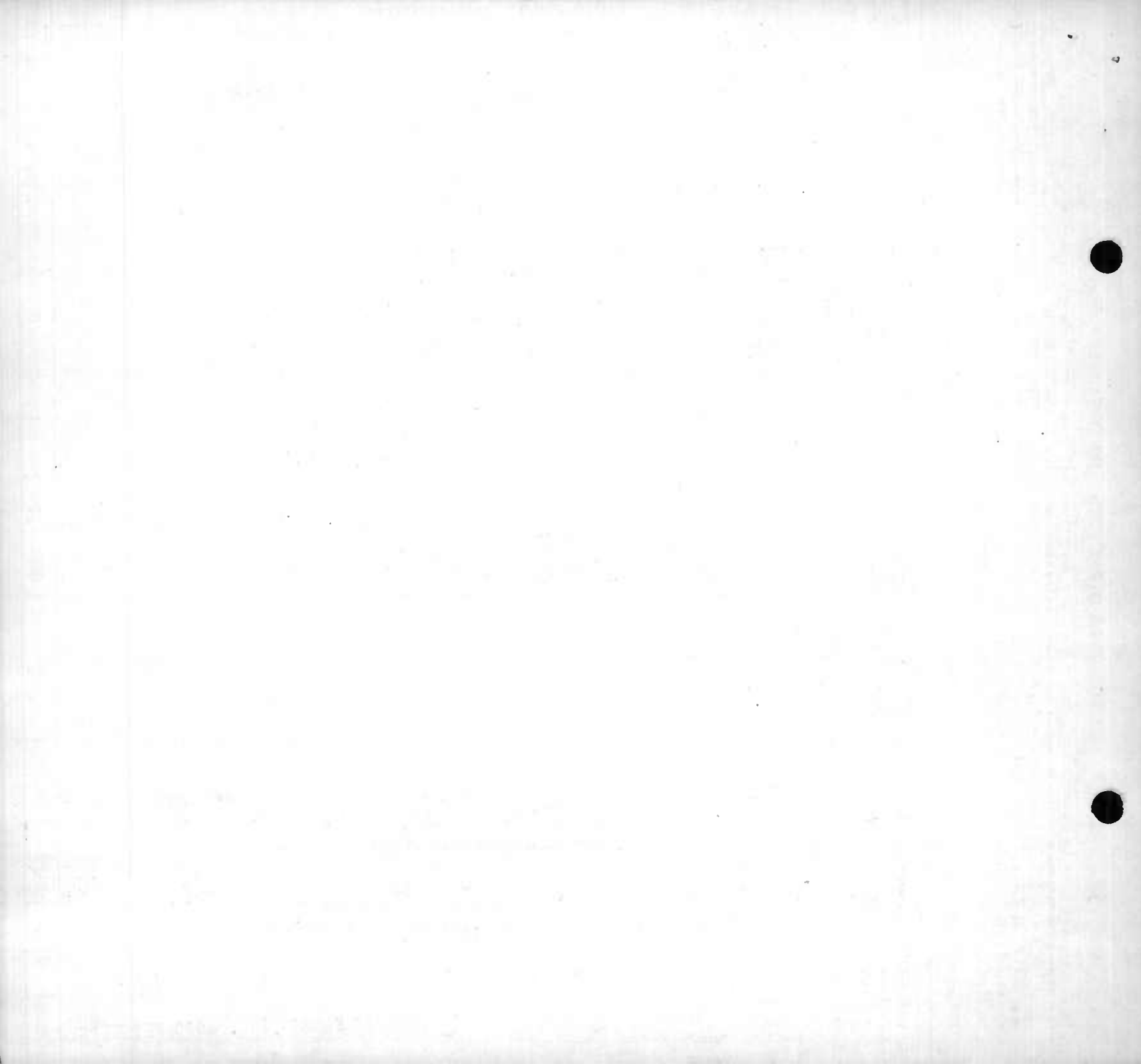
Handwritten text, possibly a signature or name, appearing upside down.



# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3684				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3684	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				AIDA GOLBERG		MARCH 31, 1965 10 P M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION				(If not in hospital or institution, give street address or location)		A. STATE MARYLAND B. COUNTY	
3208 STRATHMORE AVENUE						C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE	
				D. STREET ADDRESS (If rural, give location)		3208 STRATHMORE AVENUE	
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FEMALE	WHITE	MARRIED	5/10/1904	60	HOUSEWIFE	SHEFFIELD, ENGLAND	USA
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
HARRIS MEYER				HELEN			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO						MR. DAVID L. C. GOLBERG 3208 STRATHMORE AVE	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)				(A) DUE TO		2 months	
ANTECEDENT CAUSES				(B) DUE TO		2 1/2 months	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Congestive heart failure Coronary occlusion - Myo- cardial infarction Diabetes mellitus		20 yr.	
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1964 to Mar 31 1965, that (I) (we) last saw the deceased alive on 30 Mar 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS		Apr 1, 1965	
LOUIS HAMBURGER				1001 ST. PAUL STREET			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
BURIAL		4/2/65		PETVAH TEKVAH		ROSEDALE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 7 1965		Robert E. ...		SOL LEVINSON & BROS. INC.		6010 REISTERSTOWN RD	



1  
2.530

65 3685

BALTIMORE CITY HEALTH DEPARTMENT

65 3685

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PATRICK LUND

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965 12:40 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

38

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY Anne Arundel

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Davidsonville

D. STREET ADDRESS (If rural, give location)

St. George Barber 1Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)

Never Married

8. DATE OF BIRTH

June 14, 1944

9. AGE (In years last birthday)

22 20

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Machine Operator

10B. KIND OF BUSINESS OR INDUSTRY

Box Manf. Co.

11. BIRTHPLACE (State or foreign country)

El Paso, Texas

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Dale Lund

14. MOTHER'S MAIDEN NAME

Pollie Moran

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL SECURITY NO.

212-44-8185

17. INFORMANT

ADDRESS

Mr. Dale Lund- Father- Same As # 4

18.

E 816.4

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Massive subdural hemorrhage DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

Street

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

Route 170

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour) 4 3 65 12:12 a m.

21E. INJURY OCCURRED

WHILE AT WORK ☐

NOT WHILE AT WORK ☒

21F. HOW DID INJURY OCCUR?

Driver of auto in collision

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

April 6, 1965

23C. NAME of CEMETERY or CREMATORY

Our Lady of Sorrows

23D. LOCATION (City, town, or county) (State)

Owensville, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 7 1965

24B. NAME OF REGISTRAR

Robert E. Finken

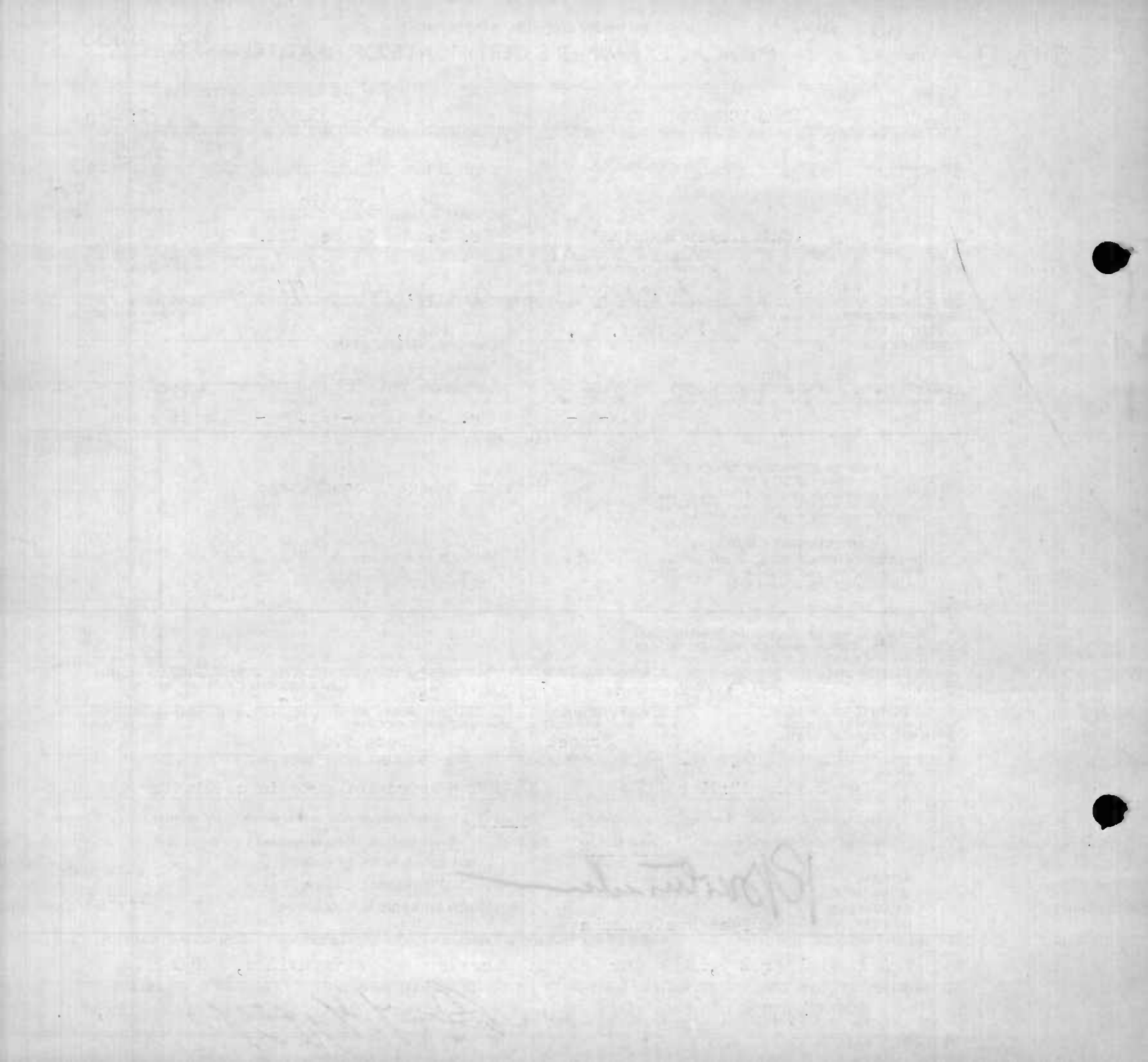
24C. FUNERAL DIRECTOR

Hopping Funeral Home

ADDRESS

Annapolis, Md.

N 804.2



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3686</b>	
<b>CERTIFICATE OF DEATH</b>			
BIRTH NO. <b>65 3686</b>		M. DATE AND HOUR OF DEATH <b>4/4/65 11 P.M.</b>	
M.E. CASE NO.			
1. NAME OF DECEASED (Type or Print) <b>Joseph F. Weber</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>University Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>18-03</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>	
		D. STREET ADDRESS (If rural, give location) <b>1216 W. Pratt St</b>	
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Married</b>	8. DATE OF BIRTH <b>2/7/1889</b>
9. AGE (In years last birthday) <b>76</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	13. FATHER'S NAME <b>Augusta Weber</b>	14. MOTHER'S MAIDEN NAME <b>Annie Smith</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS <b>Viola M. Weber, 1216 W. Pratt St</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>420.01 Cerebral thrombosis</b>		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis Ht. Disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/1</b> 19 <b>65</b> to <b>4/4</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>George D. Lawrence</b> M.D.		23B. DATE SIGNED <b>4/4/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>George D. Lawrence</b> M.D.		23D. ADDRESS <b>University Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/8/65</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Green Haven Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Green Borne, Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR ADDRESS <b>John J. Brown &amp; Son, Inc. 901 Hollins St (23) Md.</b>	

1870

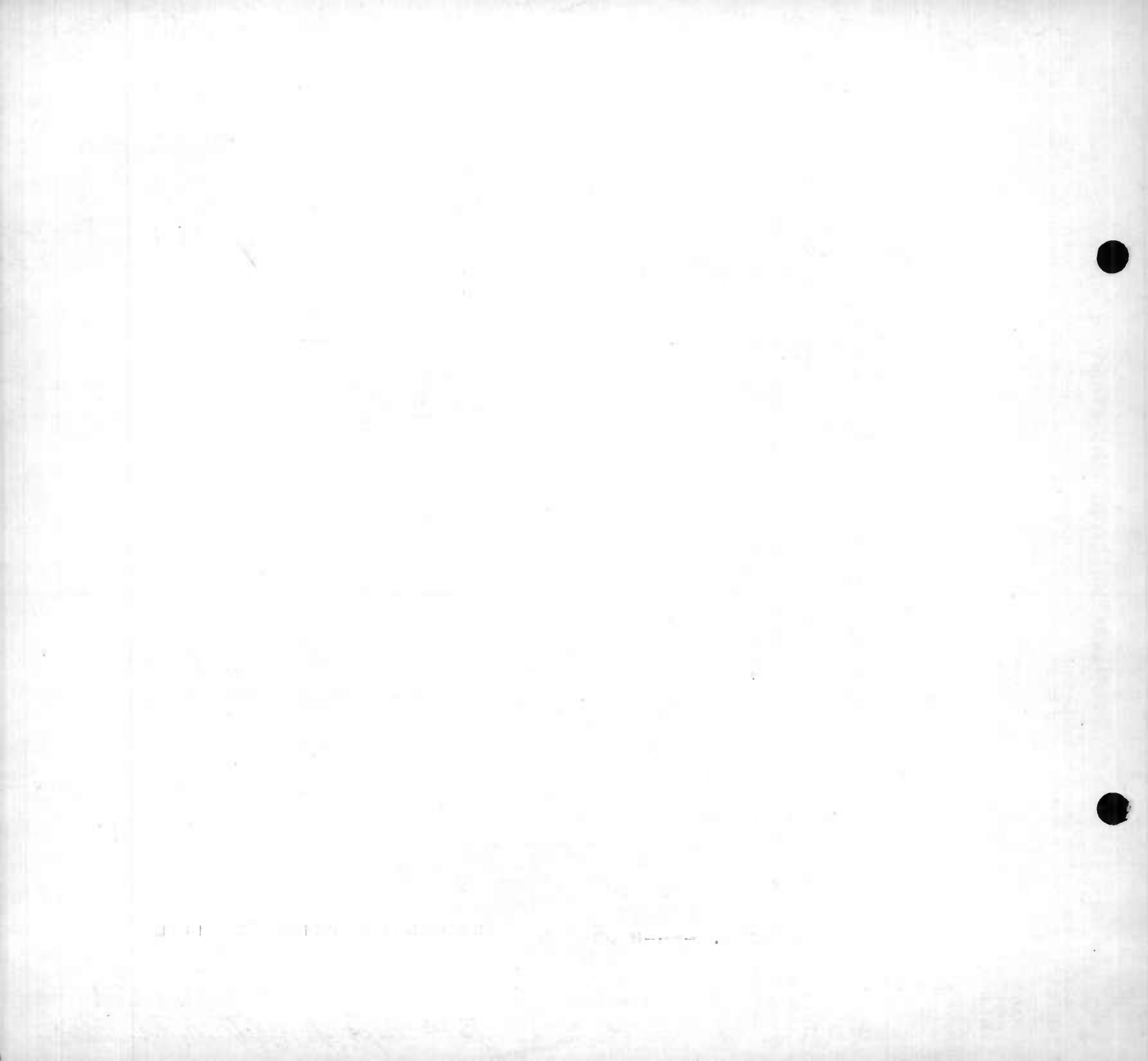
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1870

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 65 3687	
BIRTH NO. 65 3687		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) Dorothy Stephens		2. DATE AND HOUR OF DEATH 4/5/65 9:50 P.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md. B. COUNTY 27-38			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 33 Johns Hopkins Hospital		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 5638 Purdue Ave #12			
5. SEX F	6. RACE W	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED, (specify) Never Married	8. DATE OF BIRTH 11/3/97	9. AGE (In years last birthday) 67	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nursing		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Kansas City, Kansas	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Herbert T. Stephens		14. MOTHER'S MAIDEN NAME Emma W. Johnston			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mrs. W. Sudborough 5338 Purdue Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury at complication which caused death.) 172X I Endometrial Carcinoma		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH ~4 years	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/15 1965 to 4/5 1965, that (I) (we) last saw the deceased alive on 4/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE James E. Jordan M.D.		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED 4/5/65	
23C. PHYSICIAN'S NAME (Type) JAMES E. JORDAN M.D.		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/65		24C. NAME of CEMETERY or CREMATORY Westminster Cemetery	
				24D. LOCATION (City, town, or county) (State) Westminster, Md.	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1965		25B. NAME OF REGISTRAR Robert E. Stanley		25C. FUNERAL DIRECTOR ADDRESS J. E. Murphy, Westminster, Md.	





F. 500

65 3688

BALTIMORE CITY HEALTH DEPARTMENT

65 3688

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE FINNEY

2. DATE AND HOUR PRONOUNCED DEAD

4/2/65

3:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

704 Whitelock St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

704 Whitelock St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

?

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

?

14. MOTHER'S MAIDEN NAME

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

Mary Alice Scott, 702 Reservoir

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) DUE TO Fatty liver

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

W. H. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/2/65

23A. BURIAL CREMATION, REMOVAL (Specify)

23B. DATE

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 7 1965

Robert E. Taylor

V. Brooks Ruggold 1463 N. Cony St

VALLEY FOLIO

VALLEY FOLIO

W. H. H. H.

M 324

65 3689

BALTIMORE CITY HEALTH DEPARTMENT

65 3689

BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES GARVEY MITCHELL

2. DATE AND HOUR PRONOUNCED DEAD

April 5, 1965

8:05 P.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1100 Whitelock Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Jan 1, 1912

9. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

D.A.V.

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Norman Mitchell

14. MOTHER'S MAIDEN NAME

Ella

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

Yes

WW II

16. SOCIAL  
SECURITY NO.

316-01-8563

17. INFORMANT

Carylon Mitchell 1100 Whitelock St

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Generalized peritonitis  
DUE TO perforation of ileum

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-9-65

23C. NAME OF CEMETERY or CREMATORY

Beth. Natl. Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 7 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

George A. Kilar 1348 N. Calhoun St.

ADDRESS



G. 600

65 3690

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3690

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MARY GRAY

2. DATE AND HOUR PRONOUNCED DEAD

April 2, 1965

8:30 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1834 Division St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

7-13-1924

9. AGE (in years  
last birthday)

41

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

BALTO. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

EDWARD WILLIS

14. MOTHER'S MAIDEN NAME

MAMIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

CLIFTON GRAY 1823 W. BALTIMORE ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty metamorphosis of liver, marked  
DUE TO

(B) DUE TO

(C) DUE TO

## ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

## II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Partial

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT NOT WHILE  
WORK AT WORK

Partial

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4-3-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-7-65

23C. NAME of CEMETERY or CREMATORY

MOUNT CALVARY

23D. LOCATION (City, town, or county) (State)

ARUNDEL Co. Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 7 1965

24B. NAME OF REGISTRAR

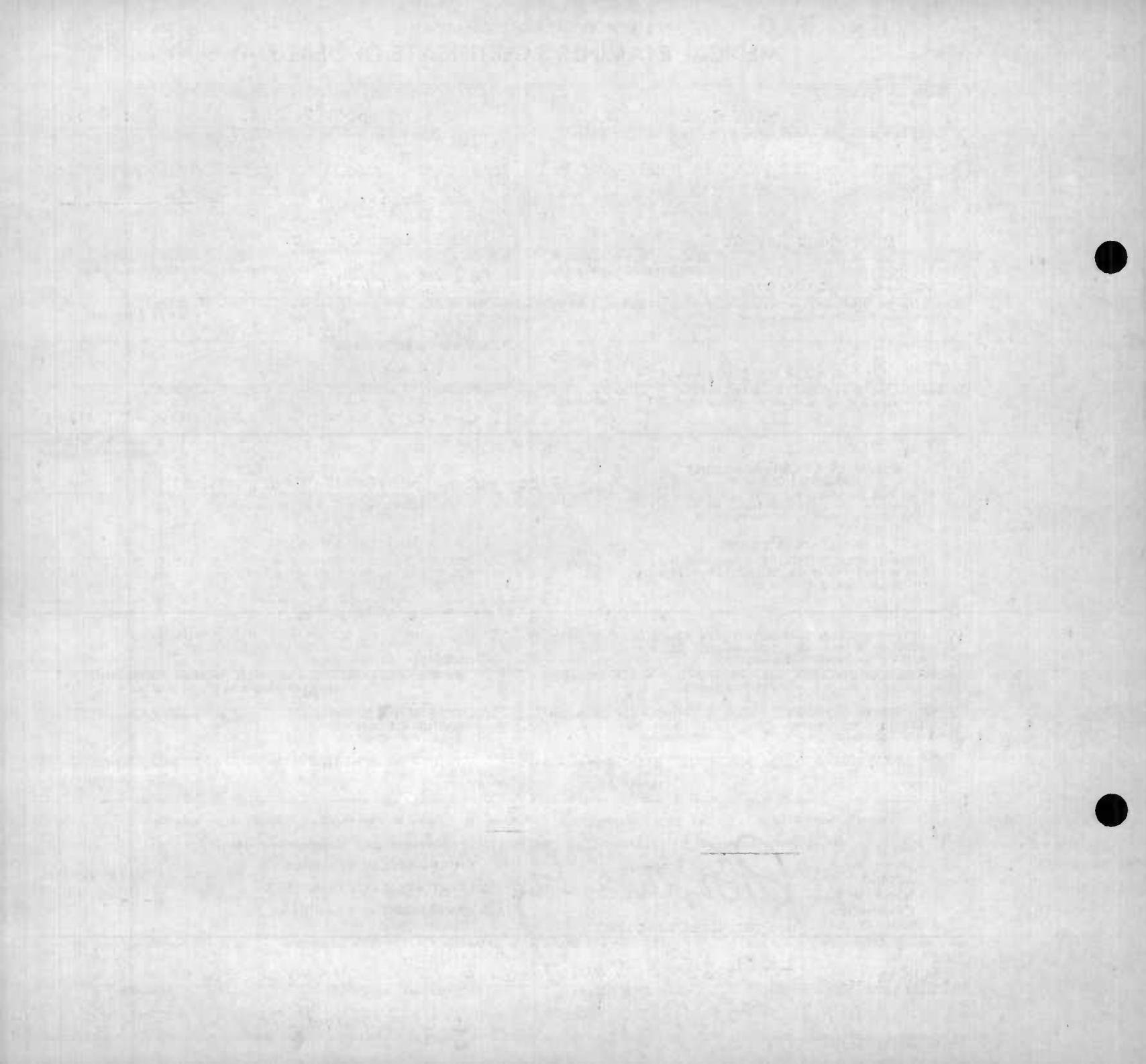
Robert E. Taylor

24C. FUNERAL DIRECTOR

J. L. BROWN &amp; SON

ADDRESS

123. W. MONTGOMERY ST.





B. 620

65 3691

BALTIMORE CITY HEALTH DEPARTMENT

65 3691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD BROCK

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965

11:56 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1823 N. Monroe St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12-14-1946

9. AGE (In years  
last birthday)

18

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MANNING S.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

CHARLIE BROCK

14. MOTHER'S MAIDEN NAME

ADA SHULER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

ADA BROCK 1823 N. MONROE ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) DUE TO Hydrocephalus

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-8-65

23C. NAME of CEMETERY or CREMATORY

MOUNT AUBURN

23D. LOCATION

(City, town, or county)

BALTO Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 7 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

J. & B. Brown & Son

ADDRESS

123 W. MONTGOMERY ST.

# WALLLEY PORGE

PROCEEDINGS

*W. Wallley*

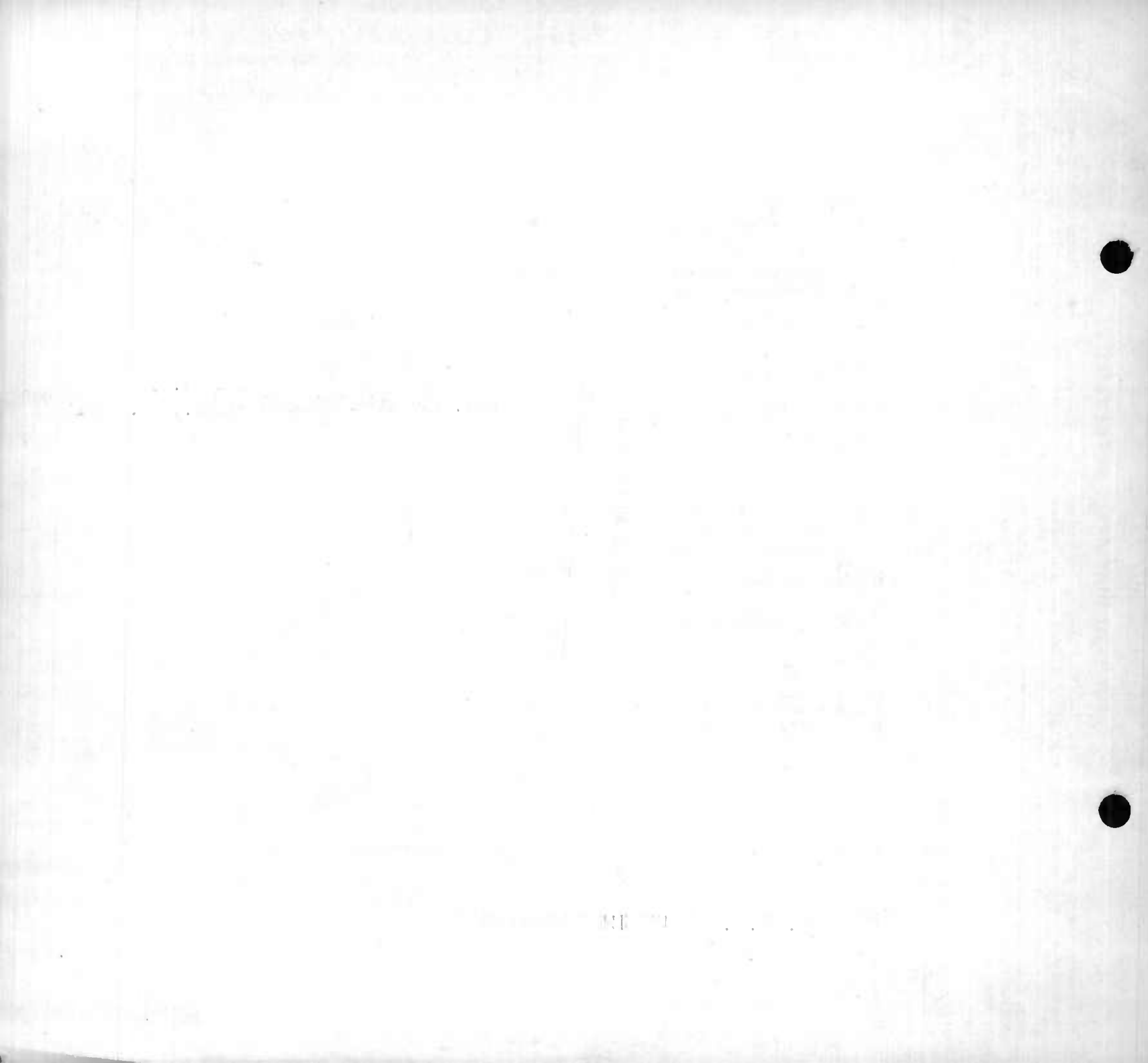


Approved and Released by Medical Examiner & Rechecked on 4/5/65 at 3:40 PM K.M. Anandiah

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

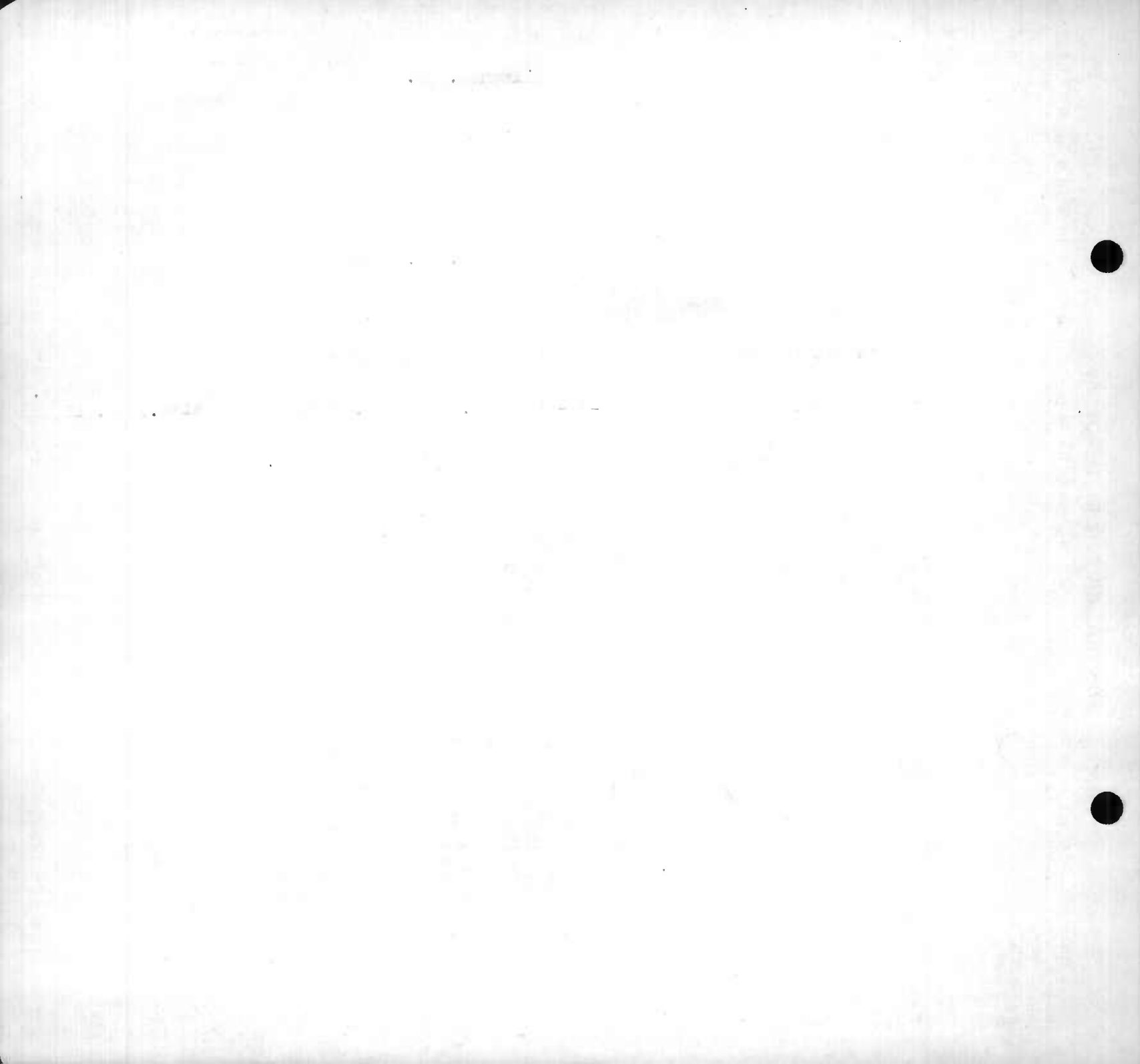
BIRTH NO. 65 3692		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3692	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NELSON SALLIE OLIVIA		2. DATE AND HOUR OF DEATH 4/5/65 1 PM		M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL		A. STATE Maryland		B. COUNTY 27-09	
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore			
		D. STREET ADDRESS (If rural, give location) 1412 E. Cold Spring Lane 21212			
5. SEX Female	6. RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed	8. DATE OF BIRTH 5-11-71	9. AGE (In years last birthday) 93	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HSWF		10B. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME George J. Buckey		14. MOTHER'S MAIDEN NAME Sarah Bopst	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Magdalene Sellman Balto., Md. 21212	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 4-22-1+1-900-7 (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH Fracture of humerus and injury to Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 3-24-65 4/5/65	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II		MEDICAL EXAMINER CHIEF OF ASS. MEDICAL EXAMINER			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Working Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Baltimore City 1412, E Cold Spring Lane	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 3/24/65 10:30 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fall Downstairs	
22. I certify that (I) (this hospital) attended the deceased from 3/24 19 65 to 4/5/ 19 65, that (I) (we) last saw the deceased alive on 4/5/ 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE K.M. Anandiah		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/5/65	
23C. PHYSICIAN'S NAME (Type) DR. K.M. ANANDIAH		23D. ADDRESS Union Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/65		24C. NAME of CEMETERY or CREMATORY Mt. Olivet Cemetery	
24D. LOCATION (City, town, or county) (State) Frederick, Md.		25A. DATE REC'D BY HEALTH DEPT. APR 7 1965		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		25D. ADDRESS		25E. ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3693</b>	
BIRTH NO. <b>65 3693</b>		<b>CERTIFICATE OF DEATH</b>	
M.E. CASE NO.		2. DATE AND HOUR OF DEATH <b>4/5/65 11:50 P.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>NOTTINGHAM - Milton G. SR.</b>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL</b>		A. STATE <b>MD</b> B. COUNTY <b>27-19</b>	
(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b>	
		D. STREET ADDRESS (If rural, give location) <b>2712 MANHATTAN - Apt #15</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <b>Feb. 10, 1891</b>
			9. AGE (In years last birthday) <b>74</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Investigator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>State Alcohol Tax Division</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>Alonzo Nottingham</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>218-01-8288</b>	17. INFORMANT <b>Mr. Milton G. Nottingham</b>
		ADDRESS <b>2712 Manhattan Ave. Balto., Md. 15</b>	
18. <b>420.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute POSTERIOR INFERIOR MI</b>		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		INTERVAL BETWEEN ONSET AND DEATH <b>80 hours?</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>4/12/65</b> to <b>4/5/65</b> 19 that (I) (we) last saw the deceased alive on <b>4/5/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Arón Ary</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> <b>A. Ary</b>	23B. DATE SIGNED <b>4/6/65</b>
23C. PHYSICIAN'S NAME (Type) <b>ARON-ARY</b>		23D. ADDRESS <b>SINAI HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>4/8/65</b>	24C. NAME of CEMETERY or CREMATORY <b>New Cathedral Cemetery Balto., Md.</b>	24D. LOCATION (City, town, or county) (State)
25A. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>Wm. H. Tishman &amp; Sons</b>	ADDRESS <b>Balto., Md. 21217</b>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

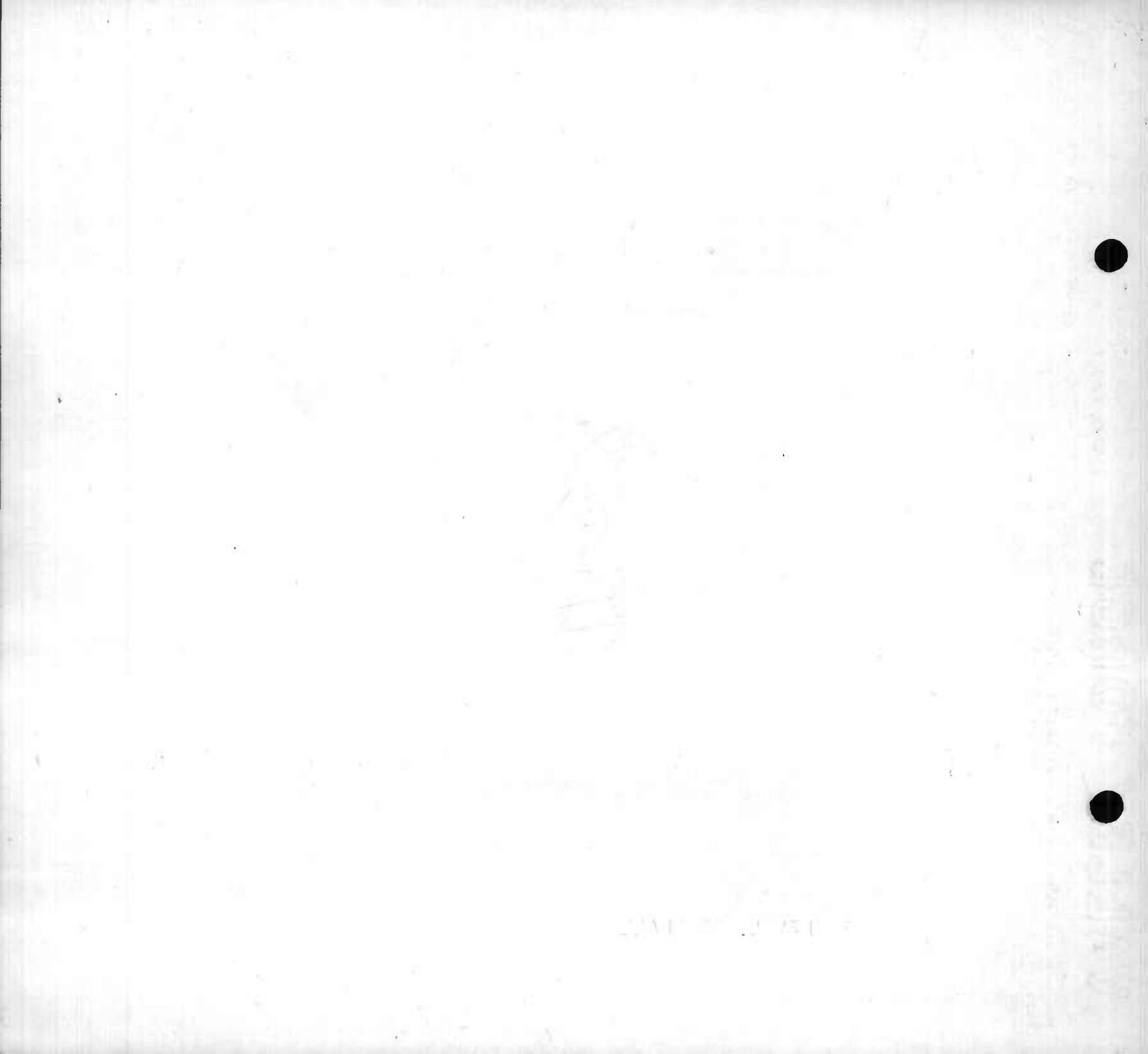
BIRTH NO. M.E. CASE NO. 1. NAME OF DECEASED (Type or Print)		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No.	
JOSEPH G. BATES JR.		2. DATE AND HOUR OF DEATH 4-5-65		7:20PM M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) D. STREET ADDRESS (If rural, give location)			
THE JOHNS HOPKINS HOSPITAL		MARYLAND Baltimore OWINGS MILLS 19 ENCHANTED HILLS RD.			
5. SEX MALE	6. RACE WHITE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) CHILD	8. DATE OF BIRTH 6-7-64	9. AGE (In years last birthday) 10	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME JOSEPH G. BATES		14. MOTHER'S MAIDEN NAME B. JEAN KRAMER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) Central Nervous System Malignancy (B) Histiocytosis X (C)		INTERVAL BETWEEN ONSET AND DEATH 2 months 7 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 2/8/1964		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Splenomegaly		20A. AUTOPSY? (Yes or No) YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/19 1965 to 4/5 1965, that (I) (we) last saw the deceased alive on 3/15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE B. W. Wilson		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/5/65	
23C. PHYSICIAN'S NAME (Type) B. W. Wilson		23D. ADDRESS M.D. J. H. H. Baltimore, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 4/8/1965		24C. NAME OF CEMETERY or CREMATORY Spring Hill Cem.	
24D. LOCATION Shippensburg, Pa.		25A. DATE REC'D BY HEALTH DEPT. APR 7 1965			
25B. NAME OF REGISTRAR Robert E. Fairbank		25C. FUNERAL DIRECTOR W. J. Anderson & Sons		ADDRESS 117 N. Baltimore	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT																
BIRTH NO. 65 3695					CERTIFICATE OF DEATH					Registered No. 65 3695						
1. NAME OF DECEASED (Type or Print) <i>Leroy Curwin Henry, Sr.</i>					2. DATE AND HOUR OF DEATH <i>4-6-65 8<sup>45</sup> A.M.</i>											
3. PLACE OF DEATH IN BALTIMORE, MARYLAND					4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)											
FULL NAME OF HOSPITAL OR INSTITUTION <i>Union Memorial Hospital</i>					A. STATE <i>Maryland</i>					B. COUNTY <i>Baltimore</i>						
(If not in hospital or institution, give street address or location)					C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>					13-06						
					D. STREET ADDRESS (If rural, give location) <i>3343 Beech Avenue</i>											
5. SEX <i>Male</i>		6. RACE <i>Cauc.</i>		7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <i>Married</i>		8. DATE OF BIRTH <i>10-22-95</i>		9. AGE (In years last birthday) <i>69</i>		If Under 1 Yr. Months: Days: Hours: Min.		If Under 24 Hrs. Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer (Retd)</i>					10B. KIND OF BUSINESS OR INDUSTRY <i>Power P.T.</i>					11. BIRTHPLACE (State or foreign country) <i>Maryland</i>					12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Lewis Henry</i>					14. MOTHER'S MAIDEN NAME <i>Henrietta Bubbs</i>											
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <i>WWI</i>					16. SOCIAL SECURITY NO. <i>NONE</i>					17. INFORMANT <i>Anna M. Henry</i>					ADDRESS <i>3343 Beech Ave.</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Pulmonary Emphysema</i>					CAUSE OF DEATH <i>also had fracture of Rib seen</i>					INTERVAL BETWEEN ONSET AND DEATH						
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.																
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																
19A. DATE OF OPERATION <i>4-4-65</i>					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No) <i>NO</i>					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Home</i>					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>At address above</i>						
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <i>4-4-65 11<sup>00</sup> PM</i>					21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input checked="" type="checkbox"/>					21F. HOW DID INJURY OCCUR? <i>Fell at Home</i>						
22. I certify that (I) (this hospital) attended the deceased from <i>4-5-65</i> to <i>4-6-65</i> , that (I) (we) last saw the deceased alive on <i>4-6-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																
23A. SIGNATURE <i>Rodney L. Brimhall</i>					23B. DATE SIGNED <i>4-6-65</i>											
23C. PHYSICIAN'S NAME (Type) <i>RODNEY L. BRIMHALL</i>					23D. ADDRESS <i>Union Memorial Hospital</i>											
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>					24B. DATE <i>4-9-65</i>					24C. NAME OF CEMETERY or CREMATORY <i>MCKELAND MEM</i>					24D. LOCATION (City, town, or county) (State) <i>BALTO MD.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 7 1965</i>					25B. NAME OF REGISTRAR <i>R. B. E. Taylor</i>					25C. FUNERAL DIRECTOR <i>Sam E. Shoverth</i>					ADDRESS <i>3436 E. Baltimore</i>	

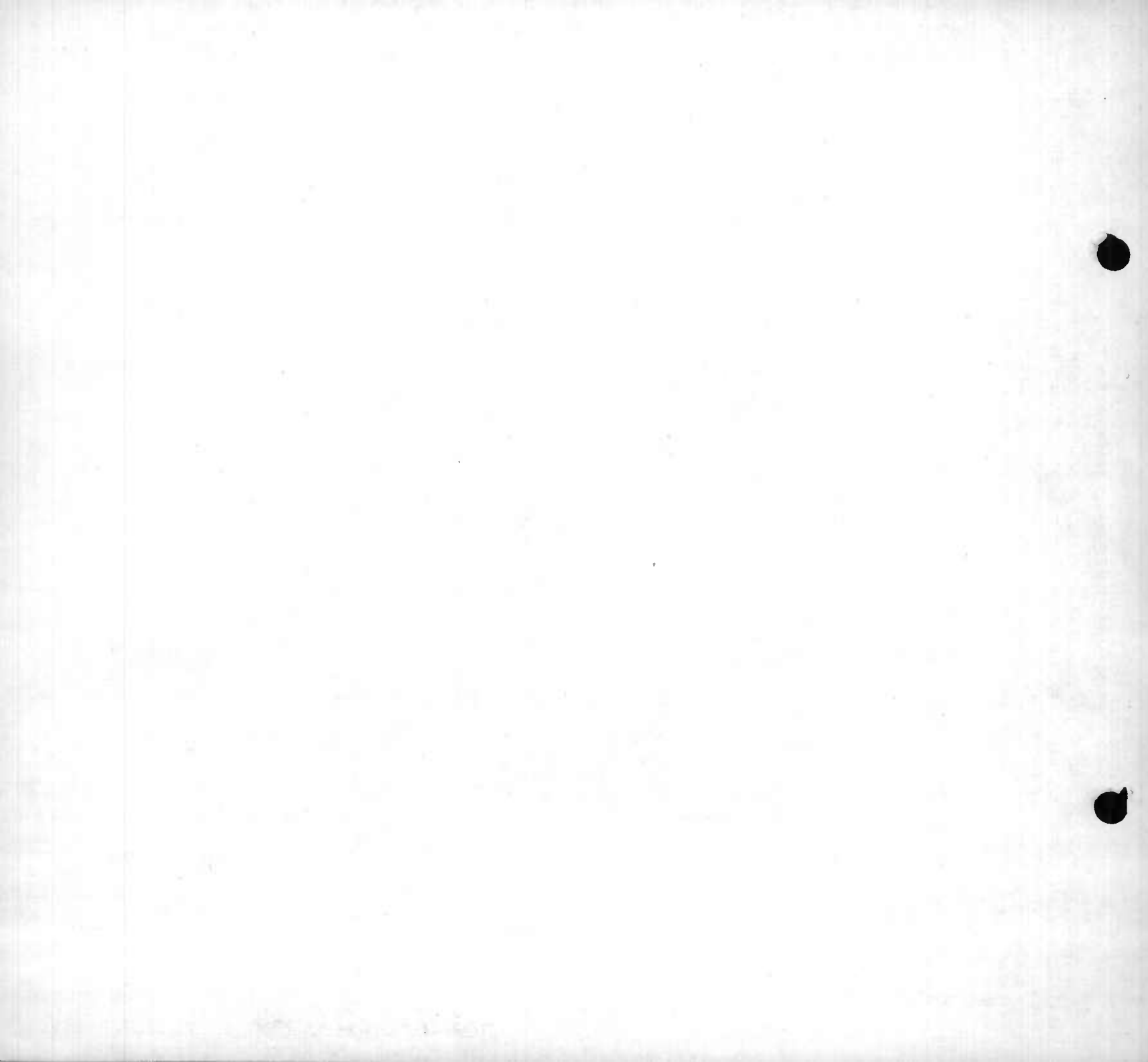




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

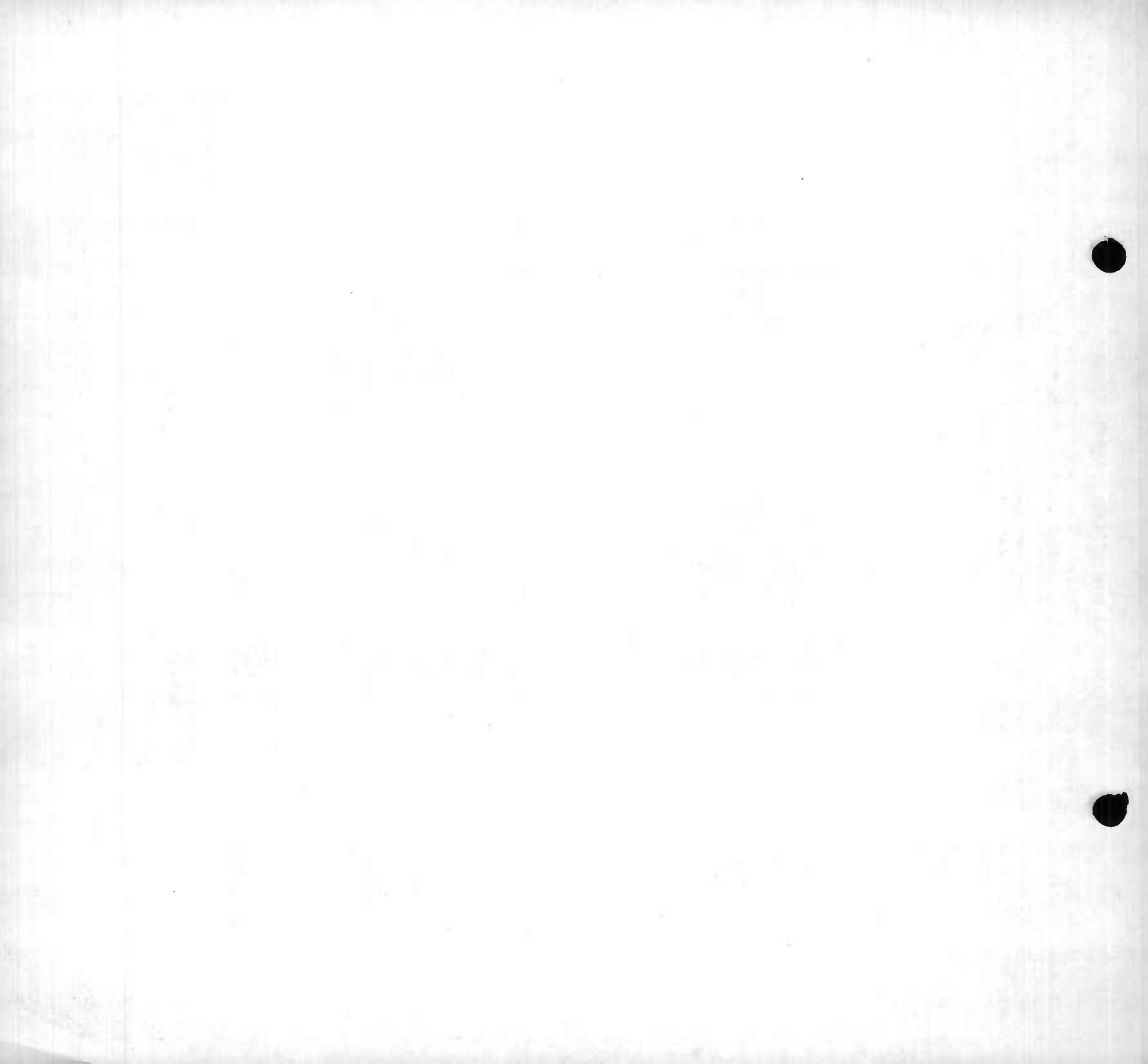
BALTIMORE CITY HEALTH DEPARTMENT																			
BIRTH NO. 65 3696					CERTIFICATE OF DEATH					Registered No. 65 3696									
M.E. CASE NO.					1. NAME OF DECEASED					2. DATE AND HOUR OF DEATH									
(Type or Print) DAVIO Berry										4/4/65 8 45 P.M.									
3. PLACE OF DEATH IN BALTIMORE, MARYLAND										4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)									
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)										A. STATE B. COUNTY									
University Hospital										Maryland									
										C. CITY OR TOWN (If outside city limits, write RURAL and give township)									
										Baltimore									
										D. STREET ADDRESS (If rural, give location)									
										1035 Orleans St.									
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Male		Negro		WIDOWED, DIVORCED (specify) married		4/20/15		49				South Carolina		USA					
13. FATHER'S NAME										14. MOTHER'S MAIDEN NAME									
Pell Berry										Emma Avery									
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)										16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No												G.D. Lawrence University Hosp.							
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH										CAUSE OF DEATH					INTERVAL BETWEEN ONSET AND DEATH				
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)										(A) Ruptured Berry Aneurysm									
ANTECEDENT CAUSES										(B) Hypertensive Heart Disease									
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.										(C) Nephrosclerosis									
II																			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.																			
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)					20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
										YES									
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)									
21D. TIME OF INJURY (APPROX.)					21E. INJURY OCCURRED					21F. HOW DID INJURY OCCUR?									
					While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>														
22. I certify that (I) (this hospital) attended the deceased from 3/29/65 to 4/4/65, that (I) (we) lost saw the deceased alive on 4/4/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																			
23A. SIGNATURE										23B. DATE SIGNED									
George D. Lawrence M.D.										4/4/65									
23C. PHYSICIAN'S NAME (Type)										23D. ADDRESS									
George D. Lawrence M.D.										University Hospital									
24A. BURIAL CREMATION, REMOVAL (Specify)					24B. DATE					24C. NAME OF CEMETERY or CREMATORY					24D. LOCATION (City, town, or county) (State)				
Burial					4/8/65					Mt Calvary Ch					Baltimore Md				
25A. DATE REC'D BY HEALTH DEPT.					25B. NAME OF REGISTRAR					25C. FUNERAL DIRECTOR					ADDRESS				
APR 7 1965					Robert E. Taylor					Clayton A. Smith					1007 Broadway Ave				



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3697				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3697	
M.E. CASE NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)				Frances Lorraine Evans		5 April 1965 6 <sup>00</sup> AM	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)		A. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				md -		B. COUNTY	
University Hospital				C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore 16	
				D. STREET ADDRESS (If rural, give location)		2508 North Ellamont St	
5. SEX		6. RACE		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Female		Negro		Married		11-28-26	
9. AGE (In years lost birthday)		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
38		Housewife		-		Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
USA		Alexander QUEEN		Ella Queen		No -	
16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		18. 467.01	
		Habit Evans		Lorraine		CAUSE OF DEATH	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) DUE TO		Hypotension +	
ANTECEDENT CAUSES		DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO		Anasarca - etiol. unknown	
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		(C)		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
2 -		-		Yes			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
-		-		-			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
-		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		-			
22. I certify that (I) (this hospital) attended the deceased from Apr. 2 1965 to Apr. 5 1965, that (I) (we) last saw the deceased alive on Apr. 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
Lorraine Camilla						4/5/65	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
FRANCINE CAMILLA				University Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		4/9/1965		Baltimore Nat'l		Baltimore	
25A. DATE REC'D BY HEALTH/DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
APR 7 1965		Robert E. Taylor		Cheryl Wilson		1000 Brantley Ave	



1  
R. 152

65 3698

BALTIMORE CITY HEALTH DEPARTMENT

65 3698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOHN ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

April 5, 1965

4:44 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2654 Harlem Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

12/25/1918

9. AGE (In years last birthday)

49

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Oscar Robinson

14. MOTHER'S MAIDEN NAME

Lillie May Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

yes

16. SOCIAL SECURITY NO.

17. INFORMANT

Elmer Robinson

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

John E. Adams

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

4/8/1965

23C. NAME OF CEMETERY or CREMATORY

Balto Nat Cal

23D. LOCATION (City, town, or county)

Balto

Md

24A. DATE REC'D BY HEALTH DEPT.

APR 7 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Elmer Robinson

ADDRESS

WALTER BORGST

TELEPHONE

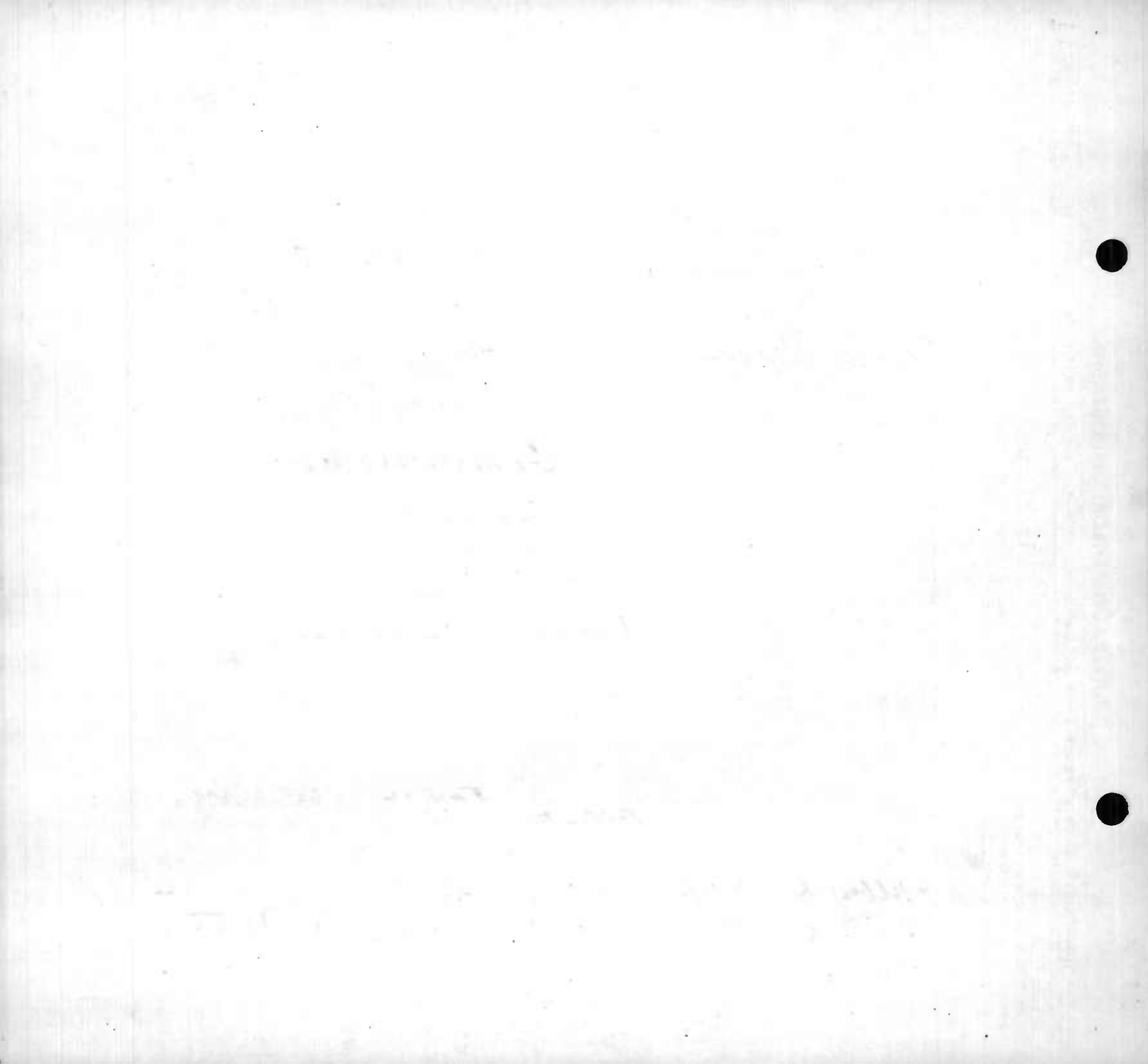
1-24

# FUNERAL DIRECTOR: IMPORTANT

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BIRTH NO. 65 3699		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3699	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Belle Camyer		4/5/65 11:55 A.M.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE B. COUNTY			
1935 Hauler Ave		Maryland 16-04			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
		Baltimore			
		D. STREET ADDRESS (If rural, give location)			
		1935 Hauler Ave			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
Female	Colored	married	12/25-1895	69	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Housewife			Baltimore Md	USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Charles Reech		Laura Jones			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS	
no			William Camyer	same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
I		(A) GENERALIZED ARTERIOSCLEROSIS			
ANTECEDENT CAUSES		(B) SENILITY			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
TERMINAL MYOCARDIAL FAILURE					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JAN 12 1965 to APRIL 5 1965, that (I) (we) last saw the deceased alive on APRIL 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED		
Gilbert L. Banfield				4/6/65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
		722 N Fulton Ave			
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY or CREMATORY	24D. LOCATION (City, town, or county) (State)		
Buried	4/9/1965	Balto Nat Cem	Balto Md		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR		ADDRESS	
APR 7 1965	Robert E. Taylor	Gloria Taylor		1000 Brantley Ave	



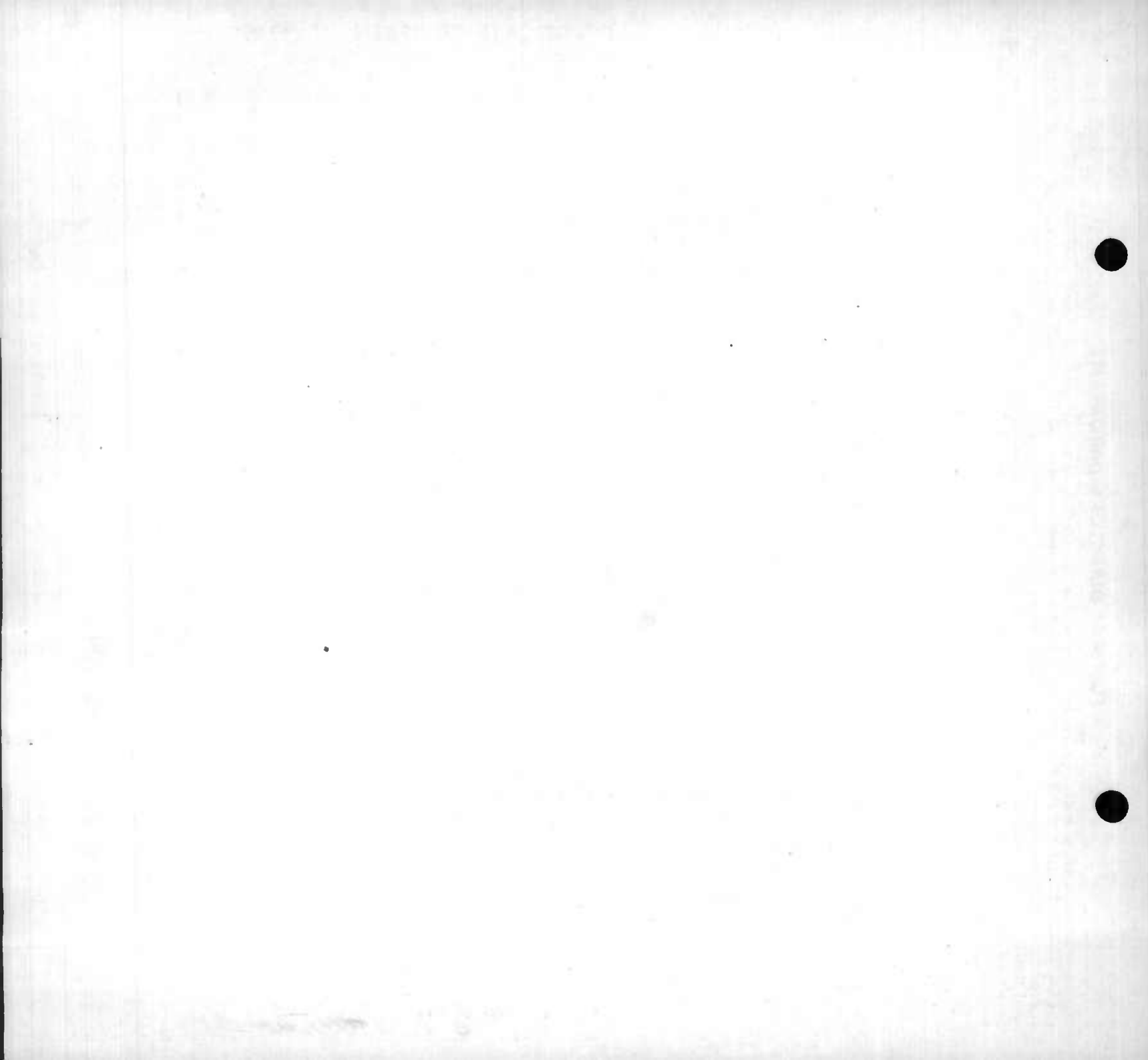




# FUNERAL DIRECTOR: IMPORTANT

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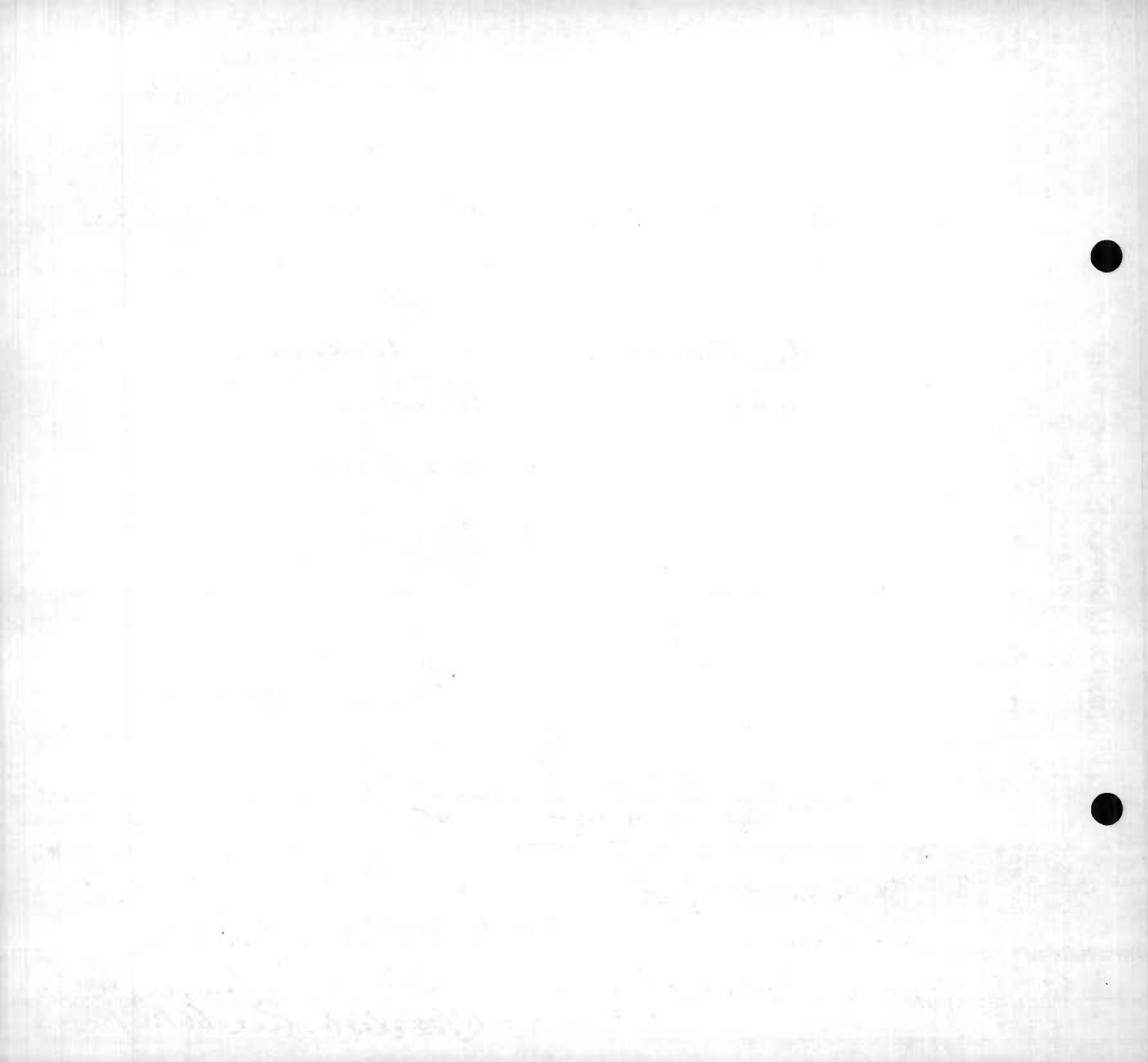
BIRTH NO. 65 3700		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3700	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) ELLIS WALTER		2. DATE AND HOUR OF DEATH 4/5/65 9:40 p.m.			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE Md B. COUNTY 18-02			
FULL NAME OF HOSPITAL OR INSTITUTION 36 FRANKLIN SQUARE HOSPITAL		C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE			
		D. STREET ADDRESS (If rural, give location) 120 SW. LEXINGTON ST			
5. SEX M	6. RACE N	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) WIDOWED	8. DATE OF BIRTH ? 1908	9. AGE (In years last birthday) 65	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) SOUTH CAROLINA	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME 1504 WALTERS		14. MOTHER'S MAIDEN NAME ELIZABETH HALLOWAY	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) ?		16. SOCIAL SECURITY NO.		17. INFORMANT Jasmy Shinnel ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 177X I METASTATIC CANCER OF THE PROSTATE		CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/22 1965 to 4/5 1965, that (I) (we) last saw the deceased alive on 4/5/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE P E BRION M.D.		Attending Physician <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Physician <input type="checkbox"/>		23B. DATE SIGNED 4/5/65	
23C. PHYSICIAN'S NAME (Type) P E BRION M.D.		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE APR 7 1965		24C. NAME OF CEMETERY or CREMATORY Everston Old Cal	
24D. LOCATION (City, town, or county) (State) Everston, Ill.		25A. DATE REC'D BY HEALTH DEPT. APR 7 1965			
25B. NAME OF REGISTRAR Robert E. ...		25C. ADDRESS 570 North ...			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3701				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3701	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Thomas Morgan</u>				2. DATE AND HOUR OF DEATH <u>4-6-65</u> <u>11:20 A.M.</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>12-05</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Bar-Wil-Ba Convalescent Home</u>				C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u>			
				D. STREET ADDRESS (If rural, give location) <u>2023 Oak Hill Howard St.</u>			
5. SEX <u>M.</u>	6. RACE <u>Col.</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH <u>7-17-87</u>	9. AGE (In years last birthday) <u>77</u>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Records</u>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.) <u>Generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>10-3-</u> <u>1962</u> to <u>4-6-</u> <u>1965</u> , that (I) (we) last saw the deceased alive on <u>4-1-</u> <u>1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <u>C.R. Campbell</u>				M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>4-6-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>C.R. Campbell</u>				23D. ADDRESS M.D. <u>1618 W. NORTH AVE</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/9/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Baltimore National</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1965</u>		25B. NAME OF REGISTRAR <u>Robert S. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Charles A. Rice</u>		ADDRESS <u>661 W. Barre</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3702		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3702	
1. NAME OF DECEASED (Type or Print) <b>IGNATIUS COFFEY</b>			2. DATE AND HOUR OF DEATH <b>4/3/65</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>11-02</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Melichor Nursing Home Charles &amp; 24th Sts. City</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b>		
D. STREET ADDRESS (If rural, give location) <b>Alcazar Hotel-Cathedral &amp; Madison</b>					
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Single</b>	8. DATE OF BIRTH	9. AGE (In years last birthday) <b>App. 83</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>			11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>John Coffey</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth (?)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Melichor N.H.</b>
18. <b>420.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>ARTERIOSCLEROTIC HEART DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Atherosclerosis</b>			<b>Indefinite</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 19 52</b> to <b>3 April 19 65</b> , that (I) (we) last saw the deceased alive on <b>3 April 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>John B. DeHoff</b>				23B. DATE SIGNED <b>5 April 65</b>	
23C. PHYSICIAN'S NAME (Type) <b>John B. DeHoff</b>				23D. ADDRESS <b>1701 Meridene Drive - Balto. 12, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/7/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Cathedral Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>City</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Estabrook M.D.</b>		25C. FUNERAL DIRECTOR <b>WIEDEFELD &amp; SON-GREENMOUNT &amp; 22ND</b>			

For the purpose of the present investigation  
the following are the results of the

24th April 1944  
25th April 1944  
26th April 1944

James Watson

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No.	
BIRTH NO. <b>65 3703</b>		<b>CERTIFICATE OF DEATH</b>		65 3703	
M.E. CASE NO.		1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
(Type or Print)		<b>McCANN, James Edward</b>		<b>April 3, 1965 17:30 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. STATE	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		Maryland		Baltimore	
<b>Veterans Administration Hospital</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township)		Baltimore	
<b>3900 Loch Raven Blvd.</b>		D. STREET ADDRESS (If rural, give location)		<b>508 Anneslie Rd.</b>	
6. SEX		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH	
Male		Single		June 10 1902	
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
62		Public Relations		Baltimore	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
		Edward A. McCann		Ellen McConnell	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
yes		WW-2		Mrs. C. McCann Sring, (Sister)	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) Recent Coronary Occlusions		12 Hours	
ANTECEDENT CAUSES		(B) Arteriosclerotic Cardio-			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		Vascular Disease			
II		(C)			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 2, 1965 to April 3, 1965, that (I) (we) last saw the deceased alive on April 3, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
<i>Anastain Hoyumpa</i>				April 3, 1965	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ANASTAIN HOYUMPA				V.A. Hospital-3900 Loch Raven Blvd.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		4/6/65		BALTIMORE NAT'L BALTO	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 7 1965		Robert E. Taylor		J. J. Greenman	
				ADDRESS	

THE UNIVERSITY OF CHICAGO  
LIBRARY  
540 EAST 57TH STREET  
CHICAGO, ILL. 60637



65 3704

BALTIMORE CITY HEALTH DEPARTMENT

65 3704

BIRTH NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM FISHER (C.H.)

2. DATE AND HOUR PRONOUNCED DEAD

April 5, 1965 3:14 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

SINAI HOSPITAL

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4117 Penhurst Avenue

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

June 3, 1894

9. AGE (In years  
last birthday)

69

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Cook

10B. KIND OF BUSINESS OR INDUSTRY

Officer's Club

11. BIRTHPLACE (State or foreign country)

Howard Co. Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William Fisher Sr.

14. MOTHER'S MAIDEN NAME

Hattie Dorsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

218-14-8226

17. INFORMANT

ADDRESS

Eleanor Spruell-4117 Penhurst Ave.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Kyphoscoliotic heart disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/8/1965

23C. NAME of CEMETERY or CREMATORY

Arbutus Memorial Pk. Baltimore Co. Maryland

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 7 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Herbert E. Nutter-3035 W. North

ADDRESS

Ave

VALLEY FORGE

HANDWRITTEN

1 - - - 1

I,

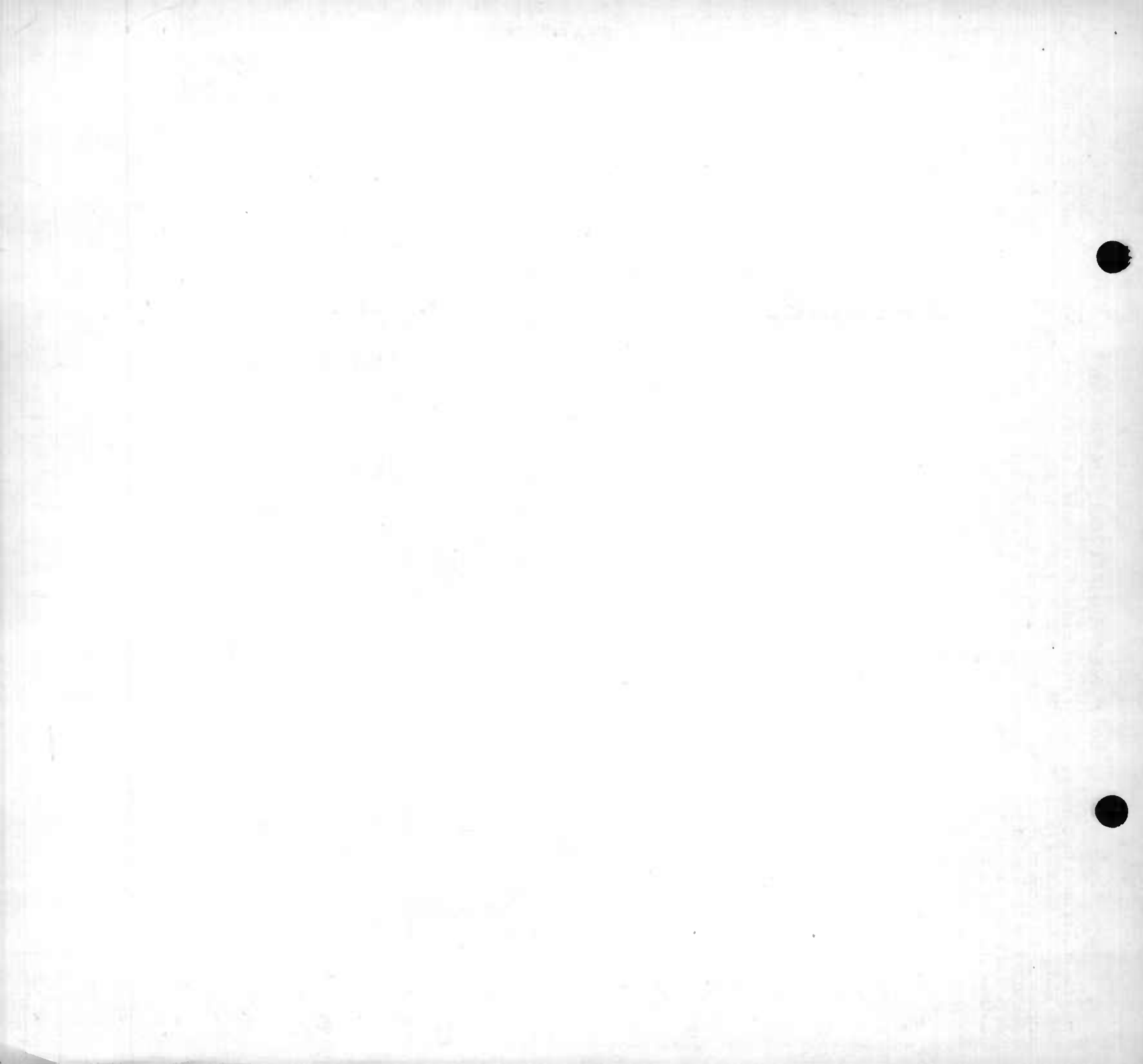
?

... ..

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3705		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3705	
M.E. CASE NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Thomas, Katherine</u>		2. DATE AND HOUR OF DEATH <u>4/6/65 12:40 am</u>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Johns Hopkins Hospital</u>		A. STATE <u>Maryland</u> B. COUNTY <u>14-82</u>			
		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore 17.</u>			
		D. STREET ADDRESS (If rural, give location) <u>1534-M<sup>2</sup> Culloch St</u>			
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widow</u>	8. DATE OF BIRTH <u>1/19/83</u>	9. AGE (In years last birthday) <u>82</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>md.</u>	
13. FATHER'S NAME <u>James Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Anna Chalk</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u>	
18. <u>133.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <u>Cardiovascular collapse</u> DUE TO (B) <u>Prolonged hypotension &amp; hypoxol.</u> DUE TO (C) <u>Obstructive Ca transverse colon</u> ? 1-2 yr.		INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 hr</u> <u>8 hr.</u> <u>? 1-2 yr.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <u>4/5/65</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstructive colon Ca</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>April 2, 1965</u> to <u>April 6, 1965</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>April 6, 1965</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> <del>(did)</del> <del>(did not)</del> view the body after death.					
23A. SIGNATURE <u>J. Peacock</u>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>4/6/65</u>	
23C. PHYSICIAN'S NAME (Type) <u>DR. PEACOCK.</u>		23D. ADDRESS <u>Johns Hopkins Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>April 19/65</u>		24C. NAME of CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>	
24D. LOCATION <u>Westport Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>APR 7 1965</u>			
25B. NAME OF REGISTRAR <u>Robert E. Farber</u>		25C. FUNERAL DIRECTOR <u>Quality Elickson</u>		25D. ADDRESS <u>1297 Chalkin</u>	



MEDICAL EXAMINER'S CASE  
 RELEASED ON APPROVAL  
 FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <b>65 3706</b>	
BIRTH NO. <b>65 3706</b>		<b>CERTIFICATE OF DEATH</b>		2. DATE AND HOUR OF DEATH <b>4-3-65 1.05 P.</b>	
1. NAME OF DECEASED (Type or Print) <b>ADA ULLICE HERRMANN</b>				3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>THE UNION MEMORIAL HOSPITAL 4/13/65</b>	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE, MD</b>		D. STREET ADDRESS (If rural, give location) <b>2812 OVERLAND AVENUE</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED <b>DIVORCED</b>	8. DATE OF BIRTH <b>7-30-1889</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE SECRETARY</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD.</b>	
12. CITIZEN OF <b>AMERICAN</b>		13. FATHER'S NAME <b>JOHN HERRMANN</b>			
14. MOTHER'S MAIDEN NAME <b>NANNIE ELAISE LAMB</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>S. S. 213-01-1224</b>			
16. Informant <b>ELIZA</b>		17. Informant <b>MR. GEORGE KIEFFNER 701 STONE LANE RD.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g. heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>RESPIRATORY FAILURE DUE TO POSS. HEMOMEDIASTINUM PARAPLEGIA DUE TO FRACTURE OF TH 4-5 VERTEBRAE &amp; FRACTURE OF LEFT WRIST</b>		19. CAUSE OF DEATH (A) DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>3.29.65 TO 4.4.65</b>	
MEDICAL CERTIFICATION					
19A. DATE OF OPERATION <b>NONE</b>					
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>--</b>					
20A. AUTOPSY? (Yes or No) <b>NO</b>					
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, in factory, street, office bldg., etc.) <b>NONE</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>FROM THE 2ND FLOOR 2812 OVERLAND AVE #14</b>	
21D. TIME OF INJURY (APPROX.) <b>3 29 65 IPM</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>PT. FELL FROM 2ND FLOOR</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3-29-65</b> 19 to <b>4-3-65</b> 19, that (I) (we) last saw the deceased alive on <b>4-3-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Steven E. Kopits</i>				23B. DATE SIGNED <b>4-5-65</b>	
23C. PHYSICIAN'S NAME (Type or Print) <b>STEVEN E. KOPITS</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/7/65</b>		24C. NAME of CEMETERY or CREMATORY <b>Druid Ridge</b>	
24D. LOCATION <b>Pikesville 8, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Witzke F.D. 4101 Edmondson Ave</b>			

VS. 153 signed by funeral Director Harry H. Witzke

C. P. Bowens

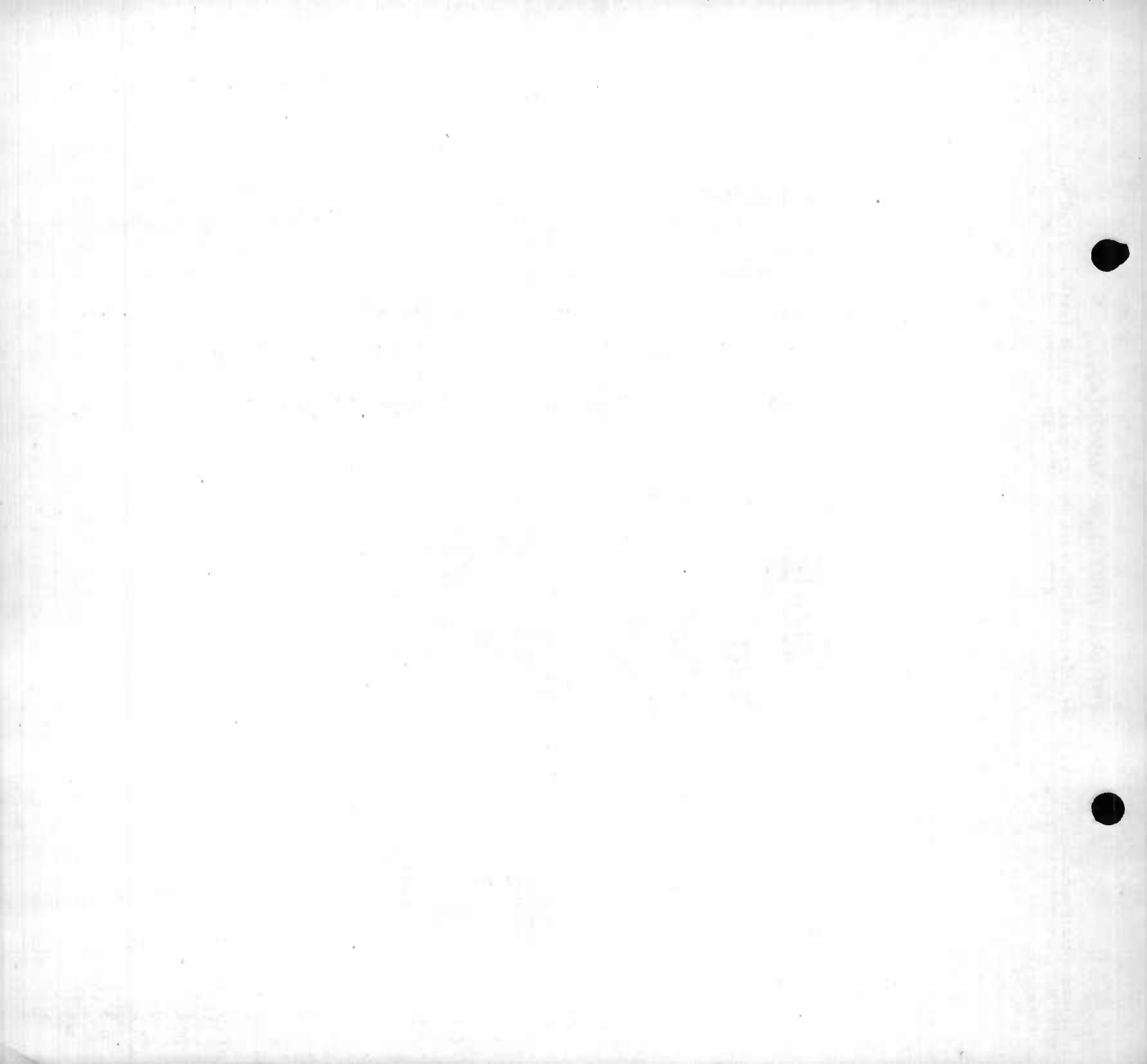
4/13/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REGISTERED NO. 65 3707	
BIRTH NO. 65 3707		CERTIFICATE OF DEATH			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) SITSKORN, ARTHUR W.		2. DATE AND HOUR OF DEATH April 6, 1965 1:35 A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md. B. COUNTY C. CITY OR TOWN (If outside city limits, write RURAL and give township) River A Beach D. STREET ADDRESS (If rural, give location) 220 Carvel Road			
5. SEX Male	6. RACE White	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Separated	8. DATE OF BIRTH 4/22/22	9. AGE (In years last birthday) 42	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anthony Sitskorn		14. MOTHER'S MAIDEN NAME Lillian B. Walker			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes World War II		16. SOCIAL SECURITY NO. 215-12-9667		17. INFORMANT ADDRESS Anthony Sitskorn 1440 Andre St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		19. CAUSE OF DEATH (A) Metastatic carcinoma of lung DUE TO (B) DUE TO (C) DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 3/8 19 65 to 4/6/65 19 65, that (I) (we) lost saw the deceased alive on 4/6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  M.D. Attending <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 4/6/65		23C. PHYSICIAN'S NAME (Type) Sukho Viriyapongse Sukhe Viriyapongse M.D.	
23D. ADDRESS 1400 N. Caroline Street, Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial	24B. DATE 4/8/65	24C. NAME of CEMETERY or CREMATORY Glen Haven Cemetery		24D. LOCATION (City, town, or county) (State) Glen Burnie, Maryland	
25A. DATE REC'D BY HEALTH DEPT. APR 7 1965		25B. NAME OF REGISTRAR Charles E. Stevens		25C. FUNERAL DIRECTOR ADDRESS Charles E. Stevens Funeral Home, Inc. 1501 E. Fort Ave.	

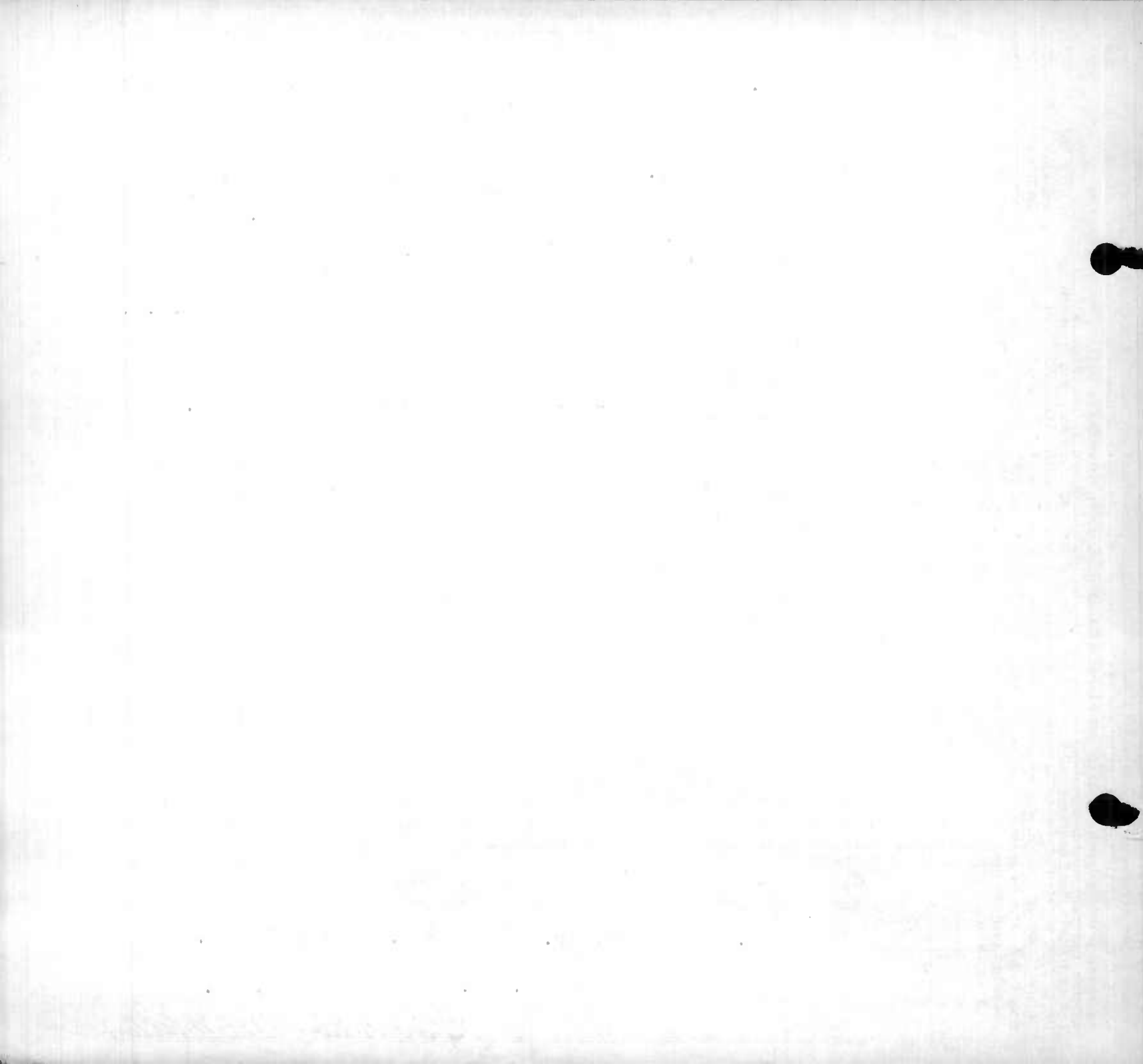




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

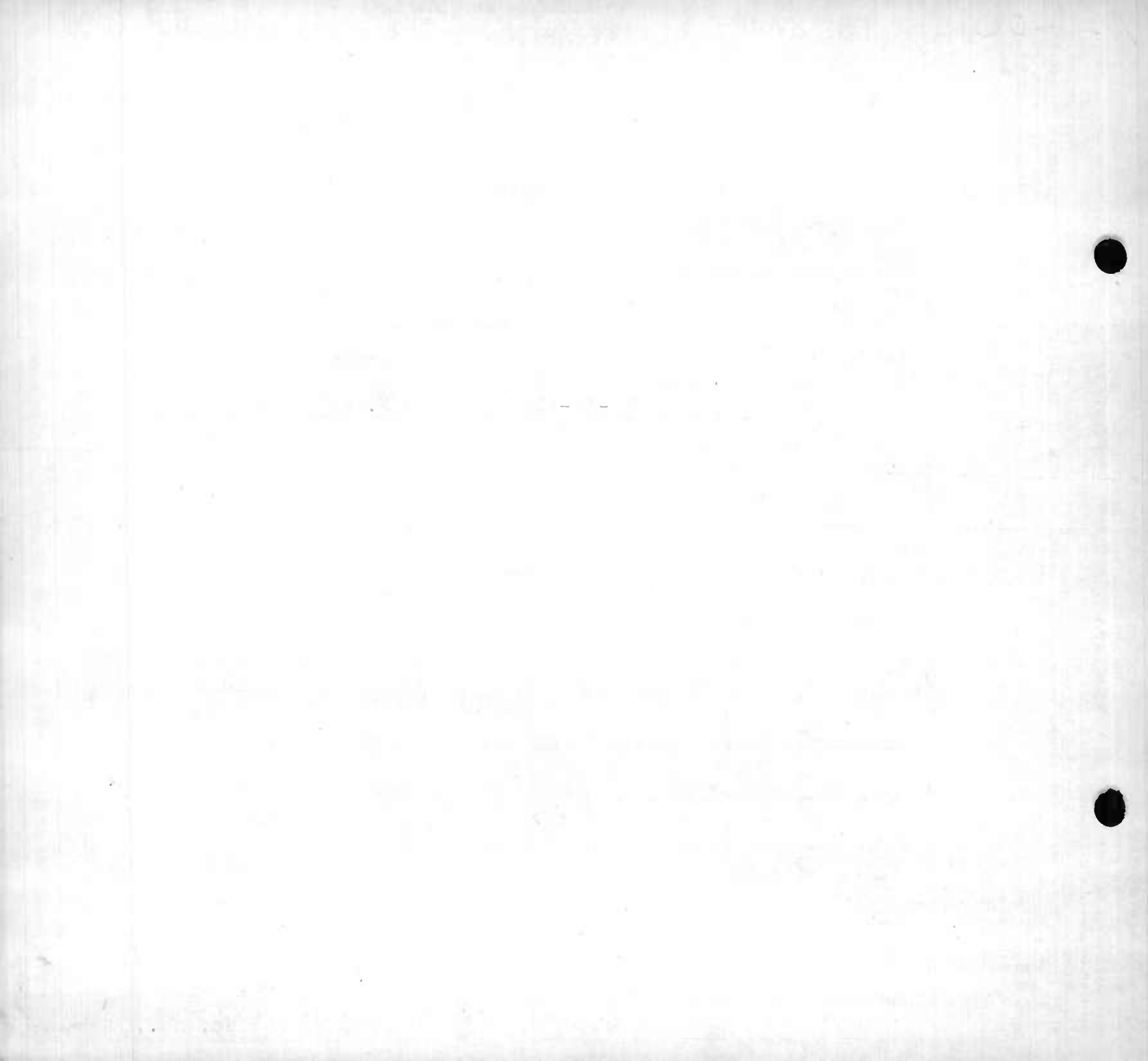
BALTIMORE CITY HEALTH DEPARTMENT				Registered No. <u>65 3708</u>	
BIRTH NO. <u>65 3708</u>		<b>CERTIFICATE OF DEATH</b>			
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <u>Mary E. Johnson</u>		2. DATE AND HOUR OF DEATH <u>April 5, 1965</u> <u>10:30</u> A.M.	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION <u>2918 Presstman St.</u> (If not in hospital or institution, give street address or location)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>16-07</u> C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u> D. STREET ADDRESS (If rural, give location) <u>2918 Presstman St.</u>		
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <u>Widowed</u>	8. DATE OF BIRTH <u>March 12; 85</u>	9. AGE (In years last birthday) <u>80</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-01-1663</u>	17. INFORMANT ADDRESS <u>Robert Johnson 2514 W. Lafayette</u>		
18. <u>422.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>Arteriosclerotic cardiovascular disease</u> (A) DUE TO (B) DUE TO (C) DUE TO  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>April 5, 1965</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Thomas J. Woolridge, Jr.</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>				23B. DATE SIGNED <u>4-7-65</u>	
23C. PHYSICIAN'S NAME (Type) <u>Thomas J. Woolridge, Jr.</u>				23D. ADDRESS <u>703 W. Lafayette Ave.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>4/8/65</u>		24C. NAME OF CEMETERY or CREMATORY <u>Arbutus Mem. Pk.</u>	
24D. LOCATION <u>Arbutus, Md.</u>		24E. DATE REC'D BY HEALTH DEPT. <u>APR 7 1965</u>			
25A. NAME OF REGISTRAR <u>R. E. Farley</u>		25B. NAME OF REGISTRAR <u>R. E. Farley</u>		25C. FUNERAL DIRECTOR ADDRESS <u>George H. Kler 1348 N. Calhoun St</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 3709</b>		BALTIMORE CITY HEALTH DEPARTMENT		Registered No. <b>65 3709</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Woodrow Nash</b>		2. DATE AND HOUR OF DEATH <b>4/5/65 7<sup>15</sup> a.m.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Sinai Hospital</b>			A. STATE <b>md</b> B. COUNTY <b>Baltimore</b>		
(If not in hospital or institution, give street address or location)			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto (24)</b>		
D. STREET ADDRESS (If rural, give location) <b>957 E/ton Ave</b>			<b>53-00</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>M</b>	8. DATE OF BIRTH <b>2-12-18</b>	9. AGE (In years lost birthday) <b>47</b>	10. CITIZEN OF WHAT COUNTRY? <b>USA</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>	
13. FATHER'S NAME <b>Lewis Nash</b>			14. MOTHER'S MAIDEN NAME <b>Saraha</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WWII</b>		16. SOCIAL SECURITY NO. <b>217-16-4103</b>		17. INFORMANT ADDRESS <b>Aileen M. Nash same as #4</b>	
18. <b>444X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Uremia</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Hypertension several yrs</b>			(B) DUE TO (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <b>3 3-31-65</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Renal Biopsy</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>no</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>—</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>no</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>—</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>—</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>3/23/65</b> to <b>4/4/65</b> 19 <b>65</b> and that (I) (we) lost saw the deceased alive on <b>4/5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard G. Shugerman</b>				23B. DATE SIGNED <b>4/5/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>Richard G. Shugerman</b>				23D. ADDRESS <b>Sinai Hosp</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>4/8/65</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore National</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>		25B. NAME OF REGISTRAR <b>R. E. Fale</b>		25C. FUNERAL DIRECTOR <b>Walter Brooks Bradley, Inc.</b>	
25D. ADDRESS <b>Dundalk 22</b>		(City, town, or county) (State)			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 65 3710				BALTIMORE CITY HEALTH DEPARTMENT		Registered No. 65 3710	
M.E. CASE NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Lindley - Sophia Mary</i>				2. DATE AND HOUR OF DEATH <i>April - 5 - 1965</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived; If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>4401 - Parkmont Ave Baltimore 21206 - Md</i>				A. STATE <i>Maryland</i> B. COUNTY <i>26-01</i>			
C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore, 21206</i>				O. STREET ADDRESS (If rural, give location) <i>4401 - Parkmont Ave</i>			
5. SEX <i>F</i>	6. RACE <i>W</i>	7. MARRIED, NEVER MARRIED WIDOWED, <del>DIVORCED</del> (specify) <i>Widowed</i>	8. DATE OF BIRTH <i>3/10/1886</i>	9. AGE (In years last birthday) <i>79</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore - Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Antone Rytina</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-05-7552</i>		17. INFORMANT <i>Mrs. Marion Delbrage</i>		ADDRESS <i>4401 - Parkmont Ave - Balto 21206 Md</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <i>Cerebro-vascular accident</i>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>arteriosclerosis</i>							
II OTHER SIGNIFICANT CONDIIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDIION CAUSING IT. <i>malnutrition</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Feb 25th</i> 19 <i>65</i> to <i>April 5th</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>March 28th</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Rafael A. Santayana</i>				M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>April 6th 65</i>	
23C. PHYSICIAN'S NAME (Type) <i>RAFAEL A. SANTAYANA</i>				23D. ADDRESS <i>6010 Eastern Ave.</i>			
24A. BURIAL CREMATION, <del>EMBALMENT</del> (Specify) <i>Burial</i>		24B. DATE <i>4/9/65</i>		24C. NAME OF CEMETERY or CREMATORY <i>Holy Redeemer</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore 21206 - Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>APR 7 1965</i>		25B. NAME OF REGISTRAR <i>R. B. C. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Carl B. Whitworth Funeral Home Inc.</i>		ADDRESS <i>6306 - Belair Rd Balto 21206, Md</i>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		Registered No.	
65 3711		CERTIFICATE OF DEATH		65 3711	
M.E. CASE NO.		1. NAME OF DECEASED (Type and Print)		2. DATE AND HOUR OF DEATH	
		Sylvia Jacobs Bodish, Cavalier		April 4, 1965	
3. PLACE OF DEATH IN		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
BALTIMORE, MARYLAND		A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township)			
Blackstone Apts - apt 805 Charles + 33rd St Baltimore 21218, Md		Baltimore 21218 12-2			
D. STREET ADDRESS (If rural, give location)		E. STREET ADDRESS (If rural, give location)			
Blackstone Apts - Charles + 33rd St		Blackstone Apts - Charles + 33rd St			
5. SEX	6. RACE	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
F	W	Widowed	Dec 18, 1877	87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housework		Home		Cincinnati Ohio	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY	
George W. Jacobs		Laura de Armonds		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		Mrs Roland R. Ballanger West Orange - N.J.	
18. 451X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
		(A) arteriosclerotic Heart Disease		1951	
		(B) Gen. arteriosclerosis		?	
		(C) Abdominal Aneurysm		1 yr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-4-1951 to 4-4-1965, that (I) (we) last saw the deceased alive on 4-4-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 1:15 P.M.					
23A. SIGNATURE		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
R. H. Siver				4-5-65	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
R. H. Siver		3105 N. Charles St. Balto. 18. Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Cremation		4/6/65		Greenmount Cemetery	
				Baltimore - Md	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
APR 7 1965		R. E. Taylor, M.D.		Woberton Funeral Home, Inc. 3636 Belair Rd., Baltimore Md.	

Handwritten text, possibly a signature or name, appearing in the center of the page.

Handwritten text, possibly a date or reference number, located in the lower left area.

Handwritten signature or name, possibly "M. H. H.", located in the lower right area.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>65 3712</b>		<b>CERTIFICATE OF DEATH</b>		Registered No. <b>65 3712</b>	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>ROBERT OICKLE</b>		2. DATE AND HOUR OF DEATH <b>4/4/65 2:00 A. M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>SINAI HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Anne Arundel</b>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>GLENBURNIE 52-00</b>	
		D. STREET ADDRESS (If rural, give location) <b>119 MARTHA ROAD</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>NEVER MARRIED</b>	8. DATE OF BIRTH <b>9/14/52</b>	9. AGE (In years last birthday) <b>12</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>MASS.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>MELBURNIE OICKLE</b>		14. MOTHER'S MAIDEN NAME <b>Eileen M. McAtee</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Charles F. Kora - (uncle) Rockville, Md</b>	
18. <b>204.21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		CAUSE OF DEATH (A) <b>Acute monocytic Leukemia</b> DUE TO (B) DUE TO (C) INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>-</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 19 1965</b> to <b>April 4 1965</b> , that (I) (we) last saw the deceased alive on <b>April 4 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Gerardo M. Tapia Jr.</b>		M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>4/4/65</b>	
23C. PHYSICIAN'S NAME (Type) <b>GERARDO M. TAPIA JR. M.D.</b>		23D. ADDRESS <b>Sinai Hospital, Balt., Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>Apr. 6/65</b>	24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>	25B. NAME OF REGISTRAR <b>R. E. Stalvey, Md.</b>	25C. FUNERAL DIRECTOR <b>R. V. Sigleton</b>		ADDRESS <b>Glen Burnie, Md.</b>	

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

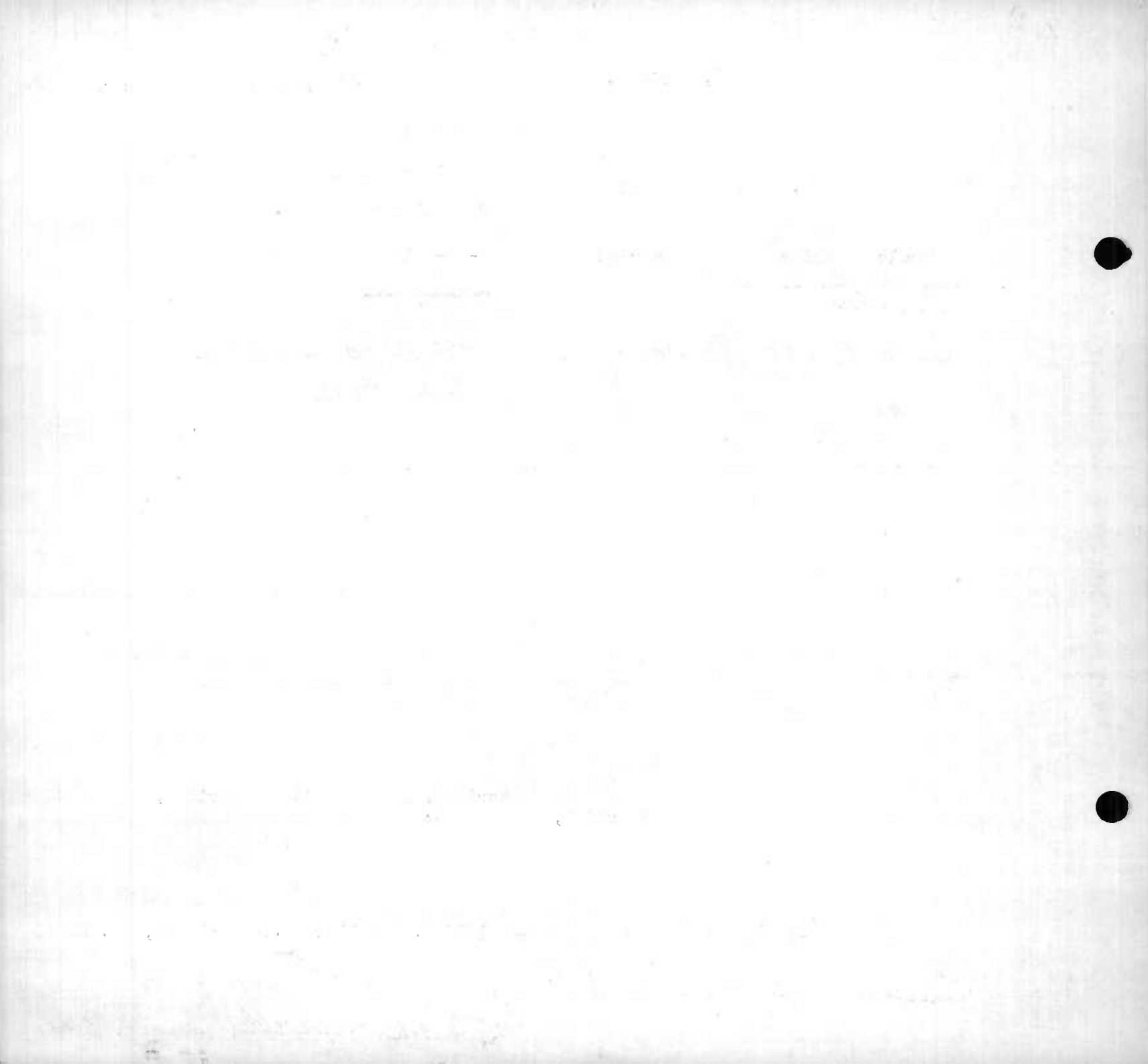
1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |                                     |
|--|--|--|--|---|-------------------------------------|
| BIRTH NO. 65 3713  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3713                        |                                     |
| M.E. CASE NO.  |  | CERTIFICATE OF DEATH   |  |   |                                     |
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  |   |                                     |
| Prol, Maria R.   |  | April 2, 1965  |  | 3:25 P.m.                                     |                                     |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) |  |   |                                     |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |  | A. STATE<br>Maryland   |  | B. COUNTY<br>Baltimore                        |                                     |
| St. Joseph Hospital  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)              |  | Baltimore 21208                               |                                     |
|  |  | D. STREET ADDRESS (If rural, give location)  |  | 600 Reisterstown Rd.                          |                                     |
| 5. SEX   | 6. RACE  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)                             | 8. DATE OF BIRTH   | 9. AGE (In years lost birthday)               | 10. If Under 1 Yr. Months Days      |
| Female   | White  | Married  | 8-24-1917  | 47  |                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)     |                                     |
| Teacher  |  |  |  | Havana, Cuba                                  |                                     |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  | 12. CITIZEN OF WHAT COUNTRY?                  |                                     |
| Constantino Romero   |  | Asuncion Iglesias  |  |   |                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                         |                                     |
| No   |  |  |  | Jose PROL                                     |                                     |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH              |                                     |
| D. Generilized Carcinoma of the Breast   |  | (A) DUE TO   |  |   |                                     |
| Metastasis to the Brain  |  | (B) DUE TO   |  |   |                                     |
| ANTECEDENT CAUSES  |  | (C) DUE TO   |  |   |                                     |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  |   |                                     |
| II   |  |  |  |   |                                     |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |   |                                     |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                                     |
|  |  | no   |  |   |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |  |   |                                     |
|  |  |  |  |   |                                     |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?   |  |   |                                     |
|  |  |  |  |   |                                     |
| 22. I certify that (I) (this hospital) attended the deceased from April 2, 19 65 to April 2, 19 65, that (I) (we) lost saw the deceased alive on April 2, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |                                     |
| 23A. SIGNATURE   |  | M.D.   | Attending Phys.  | Med. Director                                 | Staff Phys.                         |
| Salvador Marse   |  |  | <input type="checkbox"/>   | <input type="checkbox"/>                      | <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS   |  | 23B. DATE SIGNED                              |                                     |
| Salvador Marse   |  | 1400 N. Caroline St., Baltimore, Md. 21213   |  | April 2 1965                                  |                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE  | 24C. NAME of CEMETERY or CREMATORY   |  | 24D. LOCATION (City, town, or county) (State) |                                     |
| Burial   | April 5 1965   | Pine Ridge   |  | Pikesville 8 md                               |                                     |
| 25A. DATE REC'D BY HEALTH DEPT.  | 25B. NAME OF REGISTRAR   | 25C. FUNERAL DIRECTOR  |  | ADDRESS                                       |                                     |
| APR 7 1965   | Robert E. Taylor   | Frank A. Spawell   |  | Pikesville 8 md                               |                                     |



B-650

65 3714

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

65 3714

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ALMA BROWN

2. DATE AND HOUR PRONOUNCED DEAD

4-5-65

4:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE  
Virginia

B. COUNTY

Frederick

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Winchester

D. STREET ADDRESS (If rural, give location)

Fay Street Echo Village

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

Oct. 19, 1907

9. AGE (In years  
last birthday)

57

If Under 1 Yr. If Under 24 Hrs.  
Months, Days, Hours, Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

At Home

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Keyser, W. Va.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

J. H. Copp

14. MOTHER'S MAIDEN NAME

Doris Sanders

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or doles of service)

No

16. SOCIAL  
SECURITY NO.

?

17. INFORMANT

ADDRESS

Robert Brown, Winchester, Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE

EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-9-1965

23C. NAME of CEMETERY or CREMATORY

Queen's Point

23D. LOCATION

(City, town, or county)

(State)

Keyser, W. Va.

24A. DATE REC'D BY HEALTH DEPT.

APR 7 1965

24B. NAME OF REGISTRAR

Peter W. Rieckert

24C. FUNERAL DIRECTOR

F.C. Higginbotham, Ellicott City, Md  
For Jones Funeral Home, Ellicott City, Md

ADDRESS

WATLEY PROJECT  
WATLEY PROJECT  
WATLEY PROJECT



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH NO. 65 3715  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3715  |  |
| M.E. CASE NO.  |  | 1. NAME OF DECEASED Sophie Gorski  |  | 2. DATE AND HOUR OF DEATH 4/4/65 11.45 am.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br>HOSPITAL OR INSTITUTION Church Home & Hospital   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY Baltimore Md |  | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) 203   |  |
| 5. SEX Female  |  | 6. RACE White  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married  |  |
| 8. DATE OF BIRTH 10/14/27  |  | 9. AGE (In years lost birthday) 37   |  | 10. If Under 1 Yr. Months: Days: Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) Baltimore   |  |
| 12. CITIZEN OF WHAT COUNTRY? USA   |  | 13. FATHER'S NAME Adam Sucinski  |  | 14. MOTHER'S MAIDEN NAME Palcke, Miss Sophie Josephine  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) fatty cirrhosis<br>(B) acute pyelonephritis<br>(C) dilated   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  |
| 21E. INJURY OCCURRED While At Work At Work   |  | 21F. HOW DID INJURY OCCUR?   |  | 22. I certify that (I) (this hospital) attended the deceased from 3/23/65 19 to 4/4/65 19 that (I) (we) last saw the deceased alive on 4/4/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 23A. SIGNATURE Antoine Arrage  |  | 23B. DATE SIGNED 4/5/65  |  | 23C. PHYSICIAN'S NAME (Type) Antoine Arrage   |  |
| 23D. ADDRESS Church Home & Hospital  |  | 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL  |  | 24B. DATE 4-8-1965  |  |
| 24C. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY  |  | 24D. LOCATION DUNDALK  |  | 24E. DATE REC'D BY HEALTH DEPT. APR 7 1965  |  |
| 24F. NAME OF REGISTRAR Robert E. Taylor  |  | 24G. FUNERAL DIRECTOR JOHN M. WEBER  |  | 24H. ADDRESS INC 4015 CHESTER ST.   |  |



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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3716  |                     |  |                                      | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3716  |   |
|--|---------------------|--|--------------------------------------|--|---|---|---|
| M.E. CASE NO.  |                     |  |                                      | CERTIFICATE OF DEATH   |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SOPHIA KIWAKOWSKI</b>  |                     |  |                                      | 2. DATE AND HOUR OF DEATH<br><b>April 5, 1965</b> 9 A. M.  |   |   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>809 S. Montford Ave.<br/>Baltimore, Md. 21224</b>  |                     |  |                                      | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>1-04</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>809 S. Montford Avenue</b> |   |   |   |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                               | 8. DATE OF BIRTH<br><b>6/19/1896</b> |  | 9. AGE (In years last birthday)<br><b>68</b>                      | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                 |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                     |  | 10B. KIND OF BUSINESS OR INDUSTRY    |  | 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>        |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>Sylvester Stefanowicz</b>  |                     |  | 14. MOTHER'S MAIDEN NAME<br><b>?</b> |  |   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     |  | 16. SOCIAL SECURITY NO.              |  | 17. INFORMANT ADDRESS<br><b>Joseph Drzerzinski 809 S Montford</b> |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>ARTERIO-SCLEROTIC CARDIO-VASCULAR DISEASE WITH HYPERTENSION</b>   |                     |  |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>YEARS</b>   |   |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |  |                                      | (B) <b>OBSIDITY</b> <b>YEARS</b>   |   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |  |                                      |  |   |   |   |
| 19A. DATE OF OPERATION   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                      | 21F. HOW DID INJURY OCCUR?   |   |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 4</b> 19 <b>56</b> to <b>April 5</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>Mar. 17</b> 19 <b>62</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |  |                                      |  |   |   |   |
| 23A. SIGNATURE<br><b>Sigmund R. Nowak</b> M.D.   |                     |  |                                      | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |   | 23B. DATE SIGNED<br><b>April 6, 1965</b>                                  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SIGMUND R. NOWAK</b> M.D.   |                     |  |                                      | 23D. ADDRESS<br><b>408 S. PATTERSON PK. AVE.<br/>BALTIMORE MARYLAND</b>  |   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>4/8/65</b>   |                                      | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Holy Rosary Cemetery</b>  |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Co. Md.</b> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 7 1965</b>   |                     | 25B. NAME OF REGISTRAR<br><b>John M. Weber &amp; Sons Inc.</b>   |                                      | 25C. FUNERAL DIRECTOR<br><b>401 S. Chester St.</b>   |   | ADDRESS   |   |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

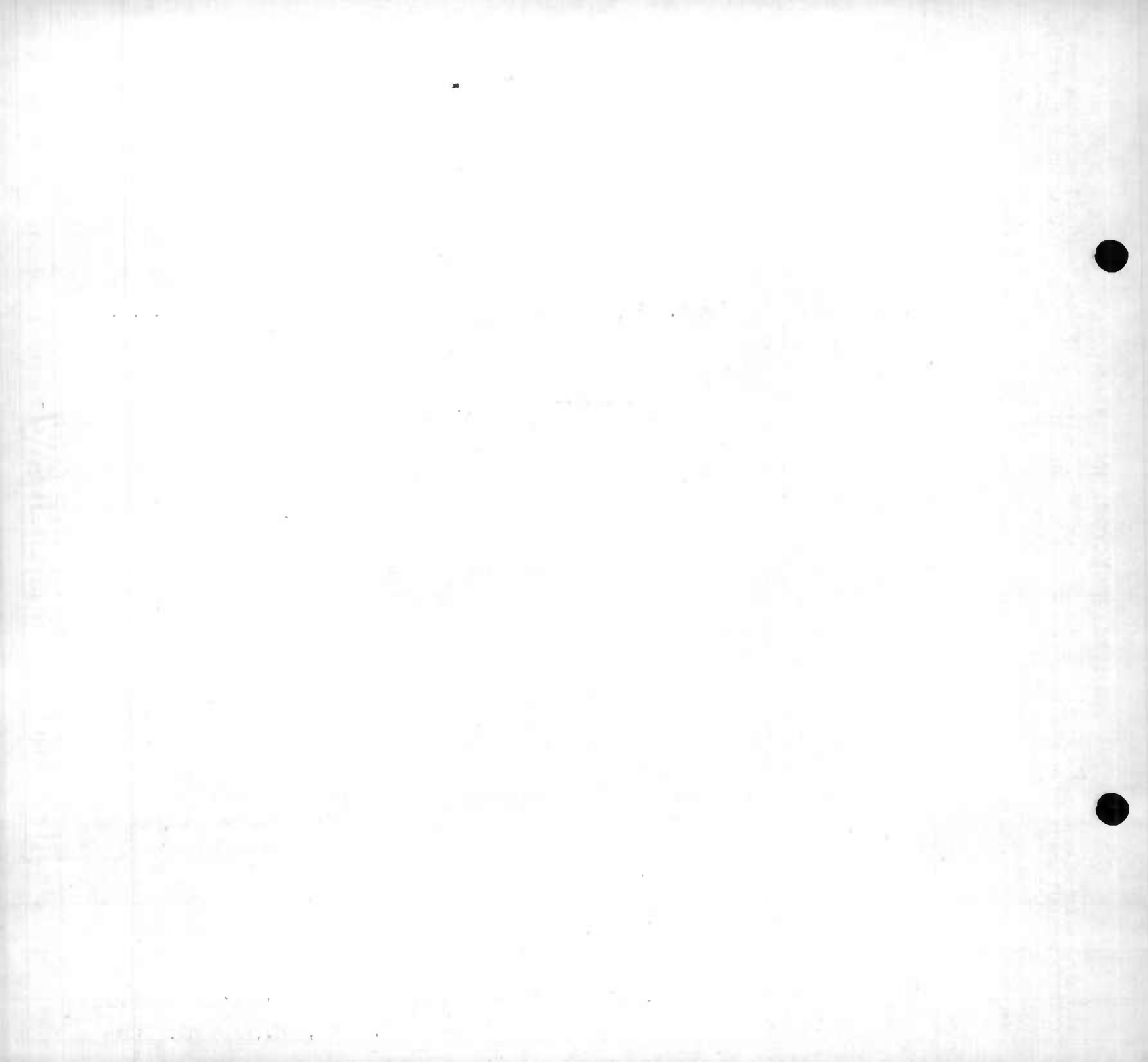
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|---|------------------|--|---|--|--|
| BIRTH NO. 65 3717   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3717   |  |
| CERTIFICATE OF DEATH  |                  |  |   |  |  |
| M.E. CASE NO.   |                  |  |   |  |  |
| 1. NAME OF DECEASED (Type or Print) <b>ROLNIAK ROLNICK</b>  |                  |  | 2. DATE AND HOUR OF DEATH <b>4-6-65 3:35 PM</b>   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)       |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Church Home &amp; Hospital</b>   |                  |  | A. STATE <b>Maryland</b> B. COUNTY <b>1-05</b>  |  |  |
|   |                  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 31</b> |  |  |
|   |                  |  | D. STREET ADDRESS (If rural, give location) <b>2107 Bank St.</b>                            |  |  |
| 5. SEX <b>M</b>   | 6. RACE <b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>married</b>  | 8. DATE OF BIRTH <b>9-21-05</b>   | 9. AGE (In years last birthday) <b>59</b>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |                  | 13. FATHER'S NAME <b>Anthony Kalnick</b>   |   | 14. MOTHER'S MAIDEN NAME <b>Angela (?)</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT <b>Cecilia LOS</b> ADDRESS <b>2120 Bank St.</b>  |  |
| 18. <b>3717 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) |                  |  | CAUSE OF DEATH  |  |  |
| ANTECEDENT CAUSES   |                  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                  |  | (A) <b>Fulminant pneumonia ? 3 days</b>   |  |  |
|   |                  |  | (B) <b>Emphysema</b>  |  |  |
|   |                  |  | (C)   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |   |  |  |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <b>NO</b>  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?  |                  | 22. I certify that (I) (this hospital) attended the deceased from <b>4-6-65</b> to <b>4-6-65</b> that (I) (we) lost saw the deceased alive on <b>4-6-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |  |
| 23A. SIGNATURE <b>Cesar R. Bariso</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                  | 23B. DATE SIGNED   |   | 23C. PHYSICIAN'S NAME (Type) <b>CESAR R. BARISO M.D.</b>   |  |
| 23D. ADDRESS <b>Church Home &amp; Hospital Balto. 31</b>  |                  | 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |   | 24B. DATE <b>4-10-65</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>HOLY ROSARY</b>   |                  | 24D. LOCATION (City, town, or county) <b>BALTIMORE Co MD</b>   |   | 24E. NAME OF REGISTRAR <b>Robert E. ...</b>  |  |
| 24F. DATE REC'D BY HEALTH DEPT. <b>APR 7 1965</b>   |                  | 24G. NAME OF REGISTRAR <b>Robert E. ...</b>  |   | 24H. FUNERAL DIRECTOR <b>JOHN M. WEDER &amp; SONS INC</b> ADDRESS <b>457 HOLLS, CHESTER ST</b>         |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

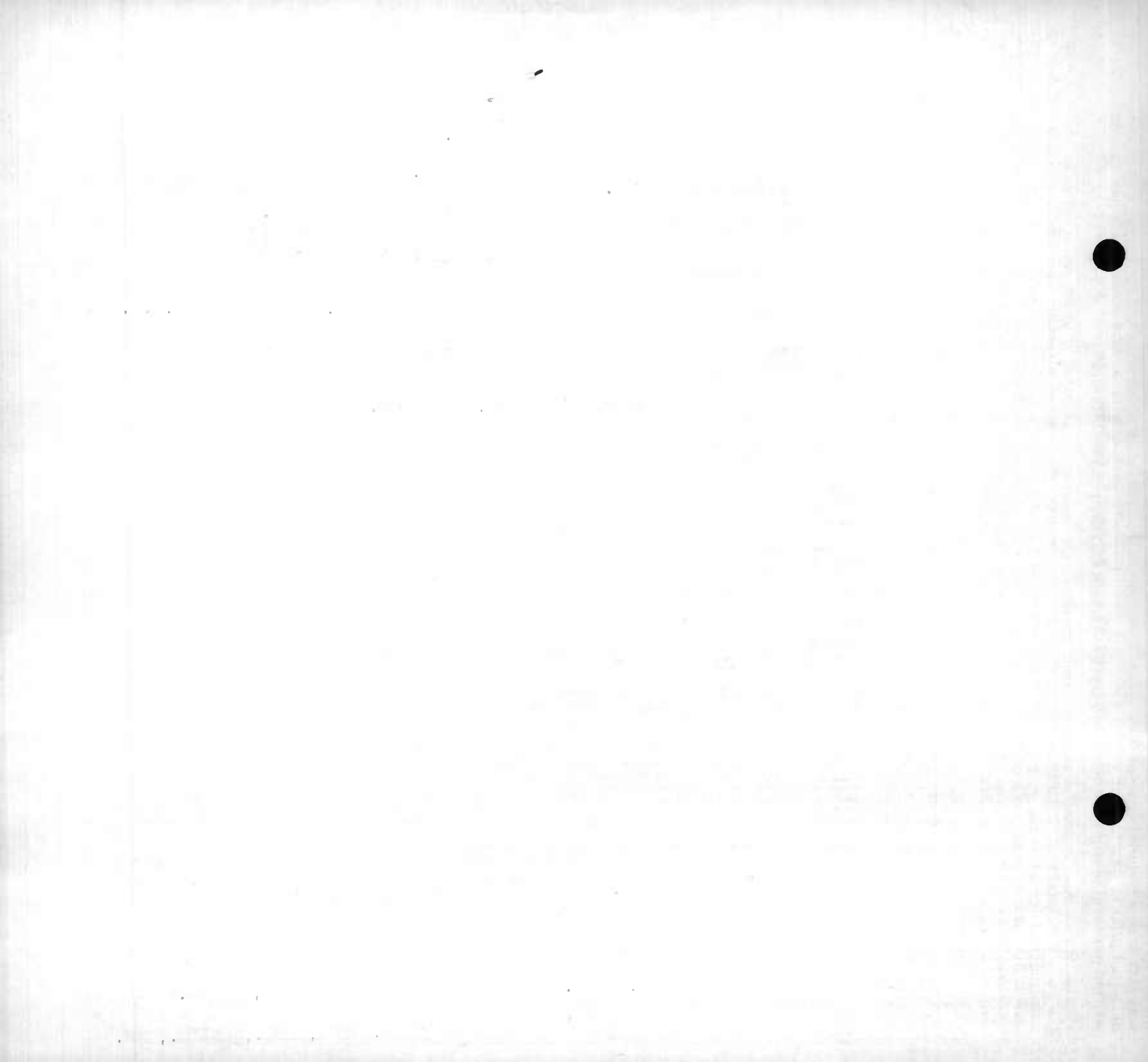
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| BIRTH NO. 65 3718   |              | BALTIMORE CITY HEALTH DEPARTMENT  |                            | Registered No. 65 3718   |  |
| M.E. CASE NO.   |              | 1. NAME OF DECEASED<br>(Type or Print) Mr. ADOLPH BISHOP  |                            | 2. DATE AND HOUR OF DEATH<br>4-5-65 11:30 PM                             |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY 27-01 |                            | M.   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>MARYLAND GENERAL HOSPITAL   |              | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE #6                                       |                            | D. STREET ADDRESS (If rural, give location)<br>5212 BIRDSON LANE         |  |
| 5. SEX<br>M   | 6. RACE<br>W | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>M   | 8. DATE OF BIRTH<br>6-6-82 | 9. AGE (In years lost birthday)<br>82                                    | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED  |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Asst. Wine Steward   |                            | 11. BIRTHPLACE (State or foreign country)<br>AUSTRIA                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |              | 13. FATHER'S NAME<br>FRANK BISHOP   |                            | 14. MOTHER'S MAIDEN NAME<br>JULIA...                                     |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |              | 16. SOCIAL SECURITY NO.<br>215031177  |                            | 17. INFORMANT<br>MRS. JULIA BISHOP                                       |  |
| 18. 260X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              | CAUSE OF DEATH<br>(A) CVA.<br>DUE TO<br>(B) Diabetes Mellitus<br>DUE TO<br>(C) Urinary retention                              |                            | INTERVAL BETWEEN ONSET AND DEATH<br>17 days.<br>ca. 15 years.            |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |              |   |                            |  |  |
| 19A. DATE OF OPERATION<br>Apr. 2, 65  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>fair  |                            | 20A. AUTOPSY? (Yes or No)<br>Yes   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                      |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                     |                            | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from May 21 1965 to Apr. 5 1965, that (I) (we) last saw the deceased alive on 10:00 PM Apr. 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                      |              |   |                            |  |  |
| 23A. SIGNATURE<br>Kyoungho M. Cynn.   |              |   |                            | 23B. DATE SIGNED<br>Apr. 6, 1965   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Kyoungho M. Cynn  |              |   |                            | 23D. ADDRESS<br>Md. General Hospital.                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL  |              | 24B. DATE<br>4/9/65   |                            | 24C. NAME of CEMETERY or CREMATORY<br>GARDENS OF FAITH CEMETERY          |  |
| 24D. LOCATION<br>BALTIMORE, MD.   |              | 25A. DATE REC'D BY HEALTH DEPT.<br>APR 7 1965   |                            |  |  |
| 25B. NAME OF REGISTRAR<br>Robert E. Fairley   |              | 25C. FUNERAL DIRECTOR<br>LEONARD J. RUCK, INC., BALTO.  |                            | 25D. ADDRESS<br>21214  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |  | BIRTH NO. 65 3719  |                            | CERTIFICATE OF DEATH   |                             | Registered No. 65 3719                        |  |
|---|-------------------------|--|--|--|----------------------------|--|-----------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Folckemmer, Charles W.</b>  |                         |  |  | 2. DATE AND HOUR OF DEATH<br><b>4-6-65 8<sup>00</sup> P. M.</b>  |                            |  |                             |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                            |  |                             |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SOUTH BALTIMORE GENERAL HOSP.</b>  |                         |  |  | A. STATE <b>MD.</b><br>B. COUNTY <b>27-09</b>  |                            |  |                             |   |  |
| (If not in hospital or institution, give street address or location)  |                         |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTO.</b>   |                            |  |                             |   |  |
|   |                         |  |  | D. STREET ADDRESS (If rural, give location)<br><b>2011 NORTHBOURNE RD.</b>   |                            |  |                             |   |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>WIDOWED</b>                             | 8. DATE OF BIRTH<br><b>4/6/1874</b>                    | 9. AGE (In years last birthday)<br><b>91</b>   | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>   |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PHARMACIST</b> |  |                            | 11. BIRTHPLACE (State or foreign country)<br><b>PENNA.</b>                 |                             | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>GEORGE FOLCKEMMER</b>   |                         |  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY</b>  |                            |  |                             |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         |  |  | 16. SOCIAL SECURITY NO.<br><b>214343164</b>  |                            | 17. INFORMANT<br><b>MR. DONALD B. FOLCKEMMER</b>                           |                             | ADDRESS<br><b>SAME</b>                        |  |
| 18. <b>332X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Thrombosis</b><br>DUE TO<br><b>Cerebral Arteriosclerosis with</b><br>DUE TO<br><b>uremia due to arteriosclerotic</b><br>DUE TO<br><b>Nephropathy</b> |                         |  |  | INTERVAL BETWEEN ONSET AND DEATH   |                            |  |                             |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |  |  |                            |  |                             |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?       |                             |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |  |                             |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |                            |  |                             |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3-29-1965</b> to <b>4-6-1965</b> , that (I) (we) last saw the deceased alive on <b>4-6-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |  |  |  |                            |  |                             |   |  |
| 23A. SIGNATURE<br><b>Kermit P. Bonovich</b>   |                         |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                            | 23B. DATE SIGNED<br><b>4-6-65</b>  |                             |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>KERMIT P. BONOVICH</b>   |                         |  |  | 23D. ADDRESS<br><b>So. Balto. Gen. Hosp.</b>   |                            |  |                             |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>4/9/65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>EVAN. LUTH. CHURCH CEMETERY</b>   |                            | 24D. LOCATION (City, town, or county) (State)<br><b>SHREWSBURY, PENNA.</b> |                             |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 7, 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Fink</b>  |  | 25C. FUNERAL DIRECTOR<br><b>LEONARD J. RUCK, INC., BALTO., MD.</b>   |                            | ADDRESS  |                             |   |  |

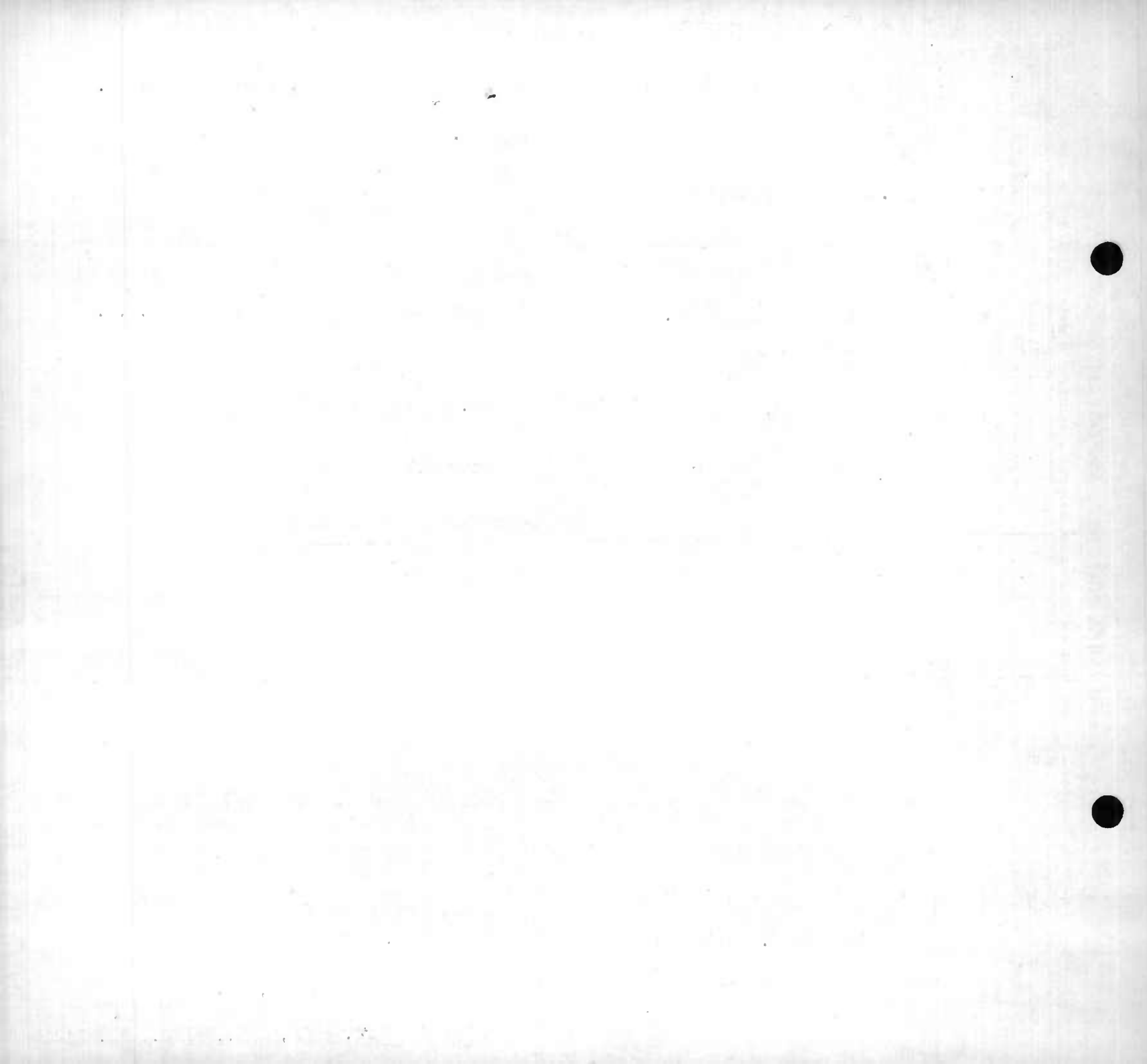




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |               |  |   |  |  |  |                                     |                                  |  |
|--|---------------|--|---|--|--|--|-------------------------------------|----------------------------------|--|
| BIRTH NO. 65 3720  |               | CERTIFICATE OF DEATH   |   |  |  |  |                                     |                                  |  |
| M.E. CASE NO.  |               | 1. NAME OF DECEASED (Type or Print) JONES, WILMER WYATT  |   |  |  | 2. DATE AND HOUR OF DEATH April 7, 1965 3:00A. M.                    |                                     |                                  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |               |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |                                     |                                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital  |               |  |   |  | A. STATE Md. B. COUNTY Balto   |  |                                     |                                  |  |
|  |               |  |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore 34 5300  |  |                                     |                                  |  |
|  |               |  |   |  | D. STREET ADDRESS (If rural, give location) 2700 Sarah Lane  |  |                                     |                                  |  |
| 5. SEX Male  | 6. RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married   | 8. DATE OF BIRTH 3/16/03                    | 9. AGE (In years last birthday) 62                                       | If Under 1 Yr. Months Days   |  | If Under 24 Hrs. Hours Min.         |                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEER   |               |  | 10B. KIND OF BUSINESS OR INDUSTRY MD. STATE |  | 11. BIRTHPLACE (State or foreign country) Maryland   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |                                  |  |
| 13. FATHER'S NAME ? JONES  |               |  | 14. MOTHER'S MAIDEN NAME ?                  |  |  |  |                                     |                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |               |  | 16. SOCIAL SECURITY NO. 216162685           |  | 17. INFORMANT MRS. LELA SEARS JONES  |  | ADDRESS SAME                        |                                  |  |
| 18. 4201 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, assthenia, etc. It means the disease, injury or complication which caused death.)  |               |  |   |  | CAUSE OF DEATH   |  |                                     | INTERVAL BETWEEN ONSET AND DEATH |  |
| ANTECEDENT CAUSES  |               |  |   |  | (A) Myocardial Infarction DUE TO   |  |                                     |                                  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |               |  |   |  | (B) Coronary Heart Disease DUE TO  |  |                                     |                                  |  |
|  |               |  |   |  | (C)  |  |                                     |                                  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |               |  |   |  |  |  |                                     |                                  |  |
| 19A. DATE OF OPERATION   |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) No   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                     |                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |                                     |                                  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |                                     |                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 4 19 65 to 4/7 1965, that (I) (we) last saw the deceased alive on 4/7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |  |   |  |  |  |                                     |                                  |  |
| 23A. SIGNATURE Glocrito G. Sagisi  |               |  |   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED 4/7/65             |                                  |  |
| 23C. PHYSICIAN'S NAME (Type) Glocrito G. Sagisi  |               |  |   |  | 23D. ADDRESS M.D. 1400 N. Caroline Street  |  |                                     |                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL  |               | 24B. DATE 4/10/65  |   | 24C. NAME of CEMETERY or CREMATORY MORELAND MEMORIAL CEMETERY            |  | 24D. LOCATION (City, town, or county) (State) BALTIMORE, MD.         |                                     |                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 7 1965   |               | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR ADDRESS 3 LEONARD J. RUCK, INC., BALTO., MD. 21214 |  |  |                                     |                                  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |                                       | Registered No. 65 3721   |  |
|---|-------------------------|--|---------------------------------------|--|--|
| BIRTH NO. 65 3721   |                         | <b>CERTIFICATE OF DEATH</b>  |                                       |  |  |
| M.E. CASE NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>ALLEN E. WOLFE</b>   |                                       | 2. DATE AND HOUR OF DEATH<br><b>4/7/65</b>   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                                       |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNION MEMORIAL HOSPITAL</b>  |                         | A. STATE <b>MD.</b><br>B. COUNTY <b>BALTO.</b>   |                                       |  |  |
| (If not in hospital or institution, give street address or location)  |                         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTO. 21204</b>                                       |                                       |  |  |
|   |                         | D. STREET ADDRESS (If rural, give location)<br><b>2202 DULANY VALLEY ROAD</b>  |                                       |  |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>   | 8. DATE OF BIRTH<br><b>10-17-1909</b> | 9. AGE (In years lost birthday)<br><b>55</b>                                       | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BRANCH MGR.</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>FOOD FAIR</b>  |                                       | 11. BIRTHPLACE (State or foreign country)<br><b>PENNA.</b>                         |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                         | 13. FATHER'S NAME<br><b>MARTIN WOLFE</b>   |                                       | 14. MOTHER'S MAIDEN NAME<br><b>ROSE STULTZMAN</b>                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.<br><b>194072669</b>  |                                       | 17. INFORMANT<br><b>MRS. H. MIRIAM WOLFE</b>                                       |  |
|   |                         |  |                                       | ADDRESS<br><b>SAME</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>420.1 I</b>  |                         | CAUSE OF DEATH<br>(A) <b>Acute coronary occlusion</b><br>DUE TO<br>(B) <b>A-S H Dis</b><br>DUE TO<br>(C) _____                       |                                       | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |  |                                       |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |                                       |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                       | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                                       | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>10-13</b> 19 <b>55</b> to <b>12-3</b> 19 <b>64</b> , that (I) (we) last saw the deceased alive on <b>12-3-</b> 19 <b>64</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                       |  |  |
| 23A. SIGNATURE<br><b>Julius M. Waghelstein</b>  |                         | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                       | 23B. DATE SIGNED<br><b>4-7-65</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Julius M. Waghelstein</b>  |                         | 23D. ADDRESS<br><b>1010 St. Paul St. Baltimore Md. 21202</b>   |                                       |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>4/10/65</b>  |                                       | 24C. NAME OF CEMETERY or CREMATORY<br><b>DULANY VALLEY MEM. GARDENS BALTO. MD.</b> |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 7 1965</b>   |                                       |  |  |
| 25B. NAME OF REGISTRAR<br><b>Richard L. ...</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>LEONARD J. RUCK, INC., BALTO. MD. 21214</b>  |                                       |  |  |



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65 3722

BALTIMORE CITY HEALTH DEPARTMENT

65 3722

| BIRTH NO.  |  |   |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  |  |  | Registered No.   |  |  |  |
|--|--|---|--|---|--|--|--|--|--|--|--|
| M.E. CASE NO.  |  |   |  | 1. NAME OF DECEASED<br>(Type or Print)  |  |  |  | 2. DATE AND HOUR PRONOUNCED DEAD                               |  |  |  |
|  |  |   |  | JOHN A. LOGAN   |  |  |  | April 7, 1965 2:40 a.m.  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) |  |  |  |  |  |  |  |
|  |  |   |  | A. STATE Maryland B. COUNTY   |  |  |  |  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  |   |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |  |  |  |  |  |  |  |
| 34 Bon Secour Hospital   |  |   |  | Baltimore   |  |  |  | 2002   |  |  |  |
| D. STREET ADDRESS (If rural, give location)  |  |   |  | 2545 W. Fairmount Avenue  |  |  |  |  |  |  |  |
| 5. SEX   |  | 6. RACE   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)                                |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)                                |  | If Under 1 Yr. II Under 24 Hrs. Months Days Hours Min. |  |
| male   |  | colored   |  | Single  |  | May 11, 1925   |  | 39   |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |  |  | 11. BIRTHPLACE (State or foreign country)                      |  | 12. CITIZEN OF WHAT COUNTRY?                           |  |
| Truck Driver   |  |   |  |   |  |  |  | Birmingham Virginia  |  |  |  |
| 13. FATHER'S NAME  |  |   |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |  |  |  |  |
| Gilbert Mack Logan   |  |   |  | Estelle Gregory Logan   |  |  |  |  |  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown; If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS  |  |  |  |
| yes WWII   |  |   |  | 219-30-2438   |  | Estelle Logan  |  | 2533 W. Fairmount Ave  |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  |   |  | CAUSE OF DEATH  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                               |  |  |  |
| 5-81.01  |  |   |  | Fatty metamorphosis of liver, severe  |  |  |  |  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  |   |  | (B) DUE TO  |  |  |  |  |  |  |  |
|  |  |   |  | (C) DUE TO  |  |  |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  | Partial   |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |  |
| 2  |  |   |  | Yes   |  | Yes  |  |  |  |  |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |  |  |  |  |
|  |  |   |  |   |  |  |  |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED  |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |  |  |  |  |
|  |  |   |  |   |  |  |  |  |  |  |  |
| 22.  |  | I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |   |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE   |  | EXAMINER'S NAME (Type)  |  | M.D.  |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                      |  | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> |  | DATE SIGNED  |  |
| Rudiger Breitenecker   |  |   |  |   |  |  |  |  |  | 4-7-65   |  |
| 23A. BURIAL CREMATION, REMOVAL (Specify)   |  | 23B. DATE   |  | 23C. NAME OF CEMETERY or CREMATORY  |  | 23D. LOCATION (City, town, or county) (State)                        |  |  |  |  |  |
| Burial   |  | 4/12/65   |  | Balt. Nat. Cem.   |  | Balt. Md   |  |  |  |  |  |
| 24A. DATE REC'D BY HEALTH DEPT.  |  | 24B. NAME OF REGISTRAR  |  | 24C. FUNERAL DIRECTOR   |  | ADDRESS  |  |  |  |  |  |
| APR 8 1965   |  | R. E. Taylor, M.D.  |  | E. E. Gilmore   |  | 1827 W. North Ave  |  |  |  |  |  |

WALLER / FIDELITY

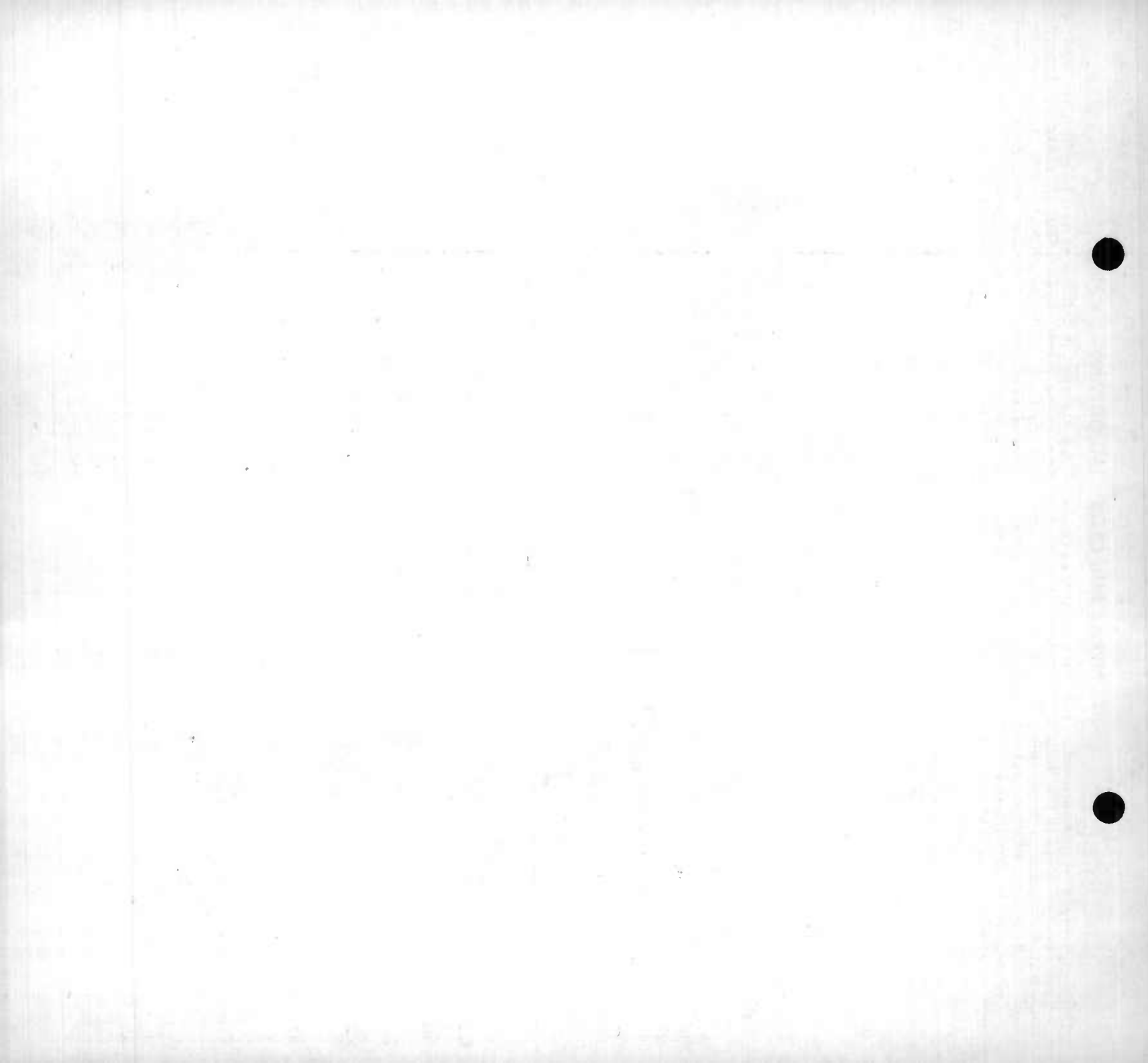
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U.S.A.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3723   |  |   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3723   |  |
|---|--|---|--|--|--|--|--|
| M.E. CASE NO.   |  |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) Margaret Hartman   |  |   |  | 2. DATE AND HOUR OF DEATH<br>April 2 /65   |  | 6.15 p m   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |  | (If not in hospital or institution, give street address or location)                                    |  | A. STATE   |  | B. COUNTY  |  |
|   |  | 527 S East Ave  |  | Maryland   |  |  |  |
| 5. SEX<br>Female  |  |   |  | 6. RACE<br>white   |  | 7. MARRIED, NEVER MARRIED<br>WIDOW                                   |  |
| 8. DATE OF BIRTH<br>Nov 9 1884  |  |   |  | 9. AGE (In years last birthday)<br>80  |  | 10. Under 1 Yr. Months Days  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                            |  |
|   |  |   |  | at home  |  | Baltimore  |  |
| 13. FATHER'S NAME<br>Joseph Arnett  |  |   |  | 14. MOTHER'S MAIDEN NAME<br>Caroline ?   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs Dorothy Roppelt 7518 Bright side Ave 6 Md       |  |
| 18. 422.1 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |   |  | CAUSE OF DEATH<br>(A) Anterior Cerebral V. Occlusion<br>DUE TO<br>(B)<br>DUE TO<br>(C)   |  | INTERVAL BETWEEN ONSET AND DEATH<br>10 yrs                           |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  | Rheumatoid Arthritis   |  | 10 yrs.  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
|   |  |   |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>Wife At Work <input type="checkbox"/> Not Wife At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 6/15/62 to 4/2 1965, that (I) (we) last saw the deceased alive on 3/31 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br>Benjamin H. Heston  |  |   |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br>4/5/65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>DR. B. H. HESTON  |  |   |  | 23D. ADDRESS<br>121 S. HIGHLAND AVE BALTO, 24 MD.  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE<br>April 6/65   |  | 24C. NAME of CEMETERY or CREMATORY<br>Oak Lawn Cemetery  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore County    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965   |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |  | 25C. FUNERAL DIRECTOR<br>Ulrich Funeral Home   |  | ADDRESS<br>4210 Belair Road  |  |

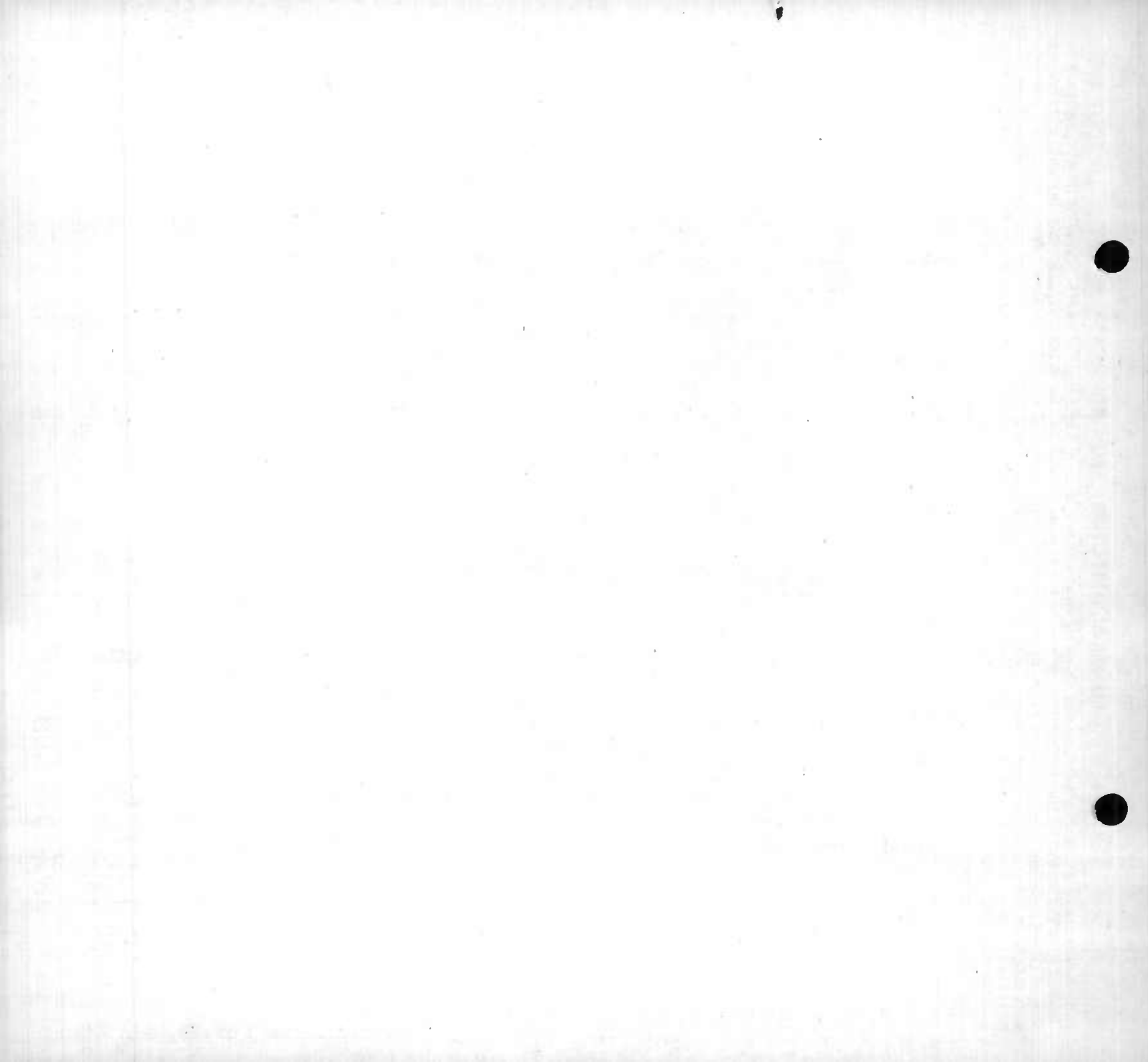




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | Baltimore City Health Department  |  | Registered No. 65 3724   |  |
|--|--|--|--|---|--|--|--|
| <b>BIRTH NO.</b> 65 3724<br><b>M.E. CASE NO.</b><br><b>1. NAME OF DECEASED</b> (Type or Print) <b>Christine E. Schott</b>  |  |  |  | <b>2. DATE AND HOUR OF DEATH</b><br><b>April 4, 1965</b>  |  |  |  |
| <b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals</b>   |  |  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br><b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>Baltimore</b><br><b>5. CITY OR TOWN</b> (If outside city limits, write RURAL and give township)<br><b>Edgemere</b><br><b>6. STREET ADDRESS</b> (If rural, give location)<br><b>2631 Edgemere Ave.</b> |  |  |  |
| <b>5. SEX</b><br><b>Female</b>   |  | <b>6. RACE</b><br><b>White</b>   |  | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)</b><br><b>Married</b>   |  | <b>8. DATE OF BIRTH</b><br><b>June 24, 1913</b>  |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>At home</b>   |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>   |  | <b>9. AGE (In years last birthday)</b><br><b>51</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Pennsylvania</b>                      |  |
| <b>13. FATHER'S NAME</b><br><b>Simon Brandt</b>  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><b>Emma</b>  |  |  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | <b>16. SOCIAL SECURITY NO.</b>   |  | <b>17. INFORMANT</b> <b>Theodore R. Schott</b> <b>ADDRESS</b> <b>2631 Edgemere Ave, 21219</b>   |  |  |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |  | <b>CAUSE OF DEATH</b><br>(A) <b>Myocarditis</b><br>(B) <b>Auto. Schott's Hb.</b><br>(C) <b>Chronic Heart fail</b>   |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><b>10 yrs.</b><br><b>10 yrs.</b><br><b>3 yrs.</b> |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>   |  |  |  |   |  |  |  |
| <b>19A. DATE OF OPERATION</b>  |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |  | <b>20A. AUTOPSY? (Yes or No)</b>  |  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>                  |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |  |  |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)   |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | <b>21F. HOW DID INJURY OCCUR?</b>   |  |  |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from Jan 15 1965 to 4-5 1965, that (I) (we) last saw the deceased alive on Jan 15 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>                                    |  |  |  |   |  |  |  |
| <b>23A. SIGNATURE</b> <i>R. Windsor</i>  |  |  |  | <b>M.D.</b> <input checked="" type="checkbox"/> <b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input type="checkbox"/>   |  | <b>23B. DATE SIGNED</b><br><b>4-6-65</b>   |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><b>Roger E. Windsor</b>   |  |  |  | <b>23D. ADDRESS</b><br><b>520 D. Street, Sparrows Point, Md.</b>  |  |  |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  | <b>24B. DATE</b><br><b>4/8/65</b>  |  | <b>24C. NAME of CEMETERY or CREMATORY</b><br><b>Oak Lawn Cemetery</b>   |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Colgate, Md.</b>                  |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>APR 8 1965</b>  |  | <b>25B. NAME OF REGISTRAR</b><br><i>R. E. Windsor</i>  |  | <b>25C. FUNERAL DIRECTOR</b> <b>Ulrich Funeral Home Dundalk, Md.</b>  |  |  |  |



| 65 3725   |         | BALTIMORE CITY HEALTH DEPARTMENT   |   | 65 3725  |   |
|---|---------|--|---|--|---|
| BIRTH NO.   |         | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |   | Registered No.   |   |
| M.E. CASE NO.   |         |  |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  | 2. DATE AND HOUR PRONOUNCED DEAD  |  |   |
| JAY CEE MILLS   |         |  | April 1, 1965 1:15 P M.   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)     |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |  | A. STATE<br>Maryland  |  |   |
| 1310 E. Eager Street  |         |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore |  |   |
|   |         |  | D. STREET ADDRESS (If rural, give location)<br>1310 E. Eager Street                       |  |   |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)                                 | 8. DATE OF BIRTH  | 9. AGE (In years<br>last birthday)                                       | If Under 1 Yr. II Under 24 Hrs.<br>Months Days Hours Min. |
| Male  | Negro   | Separated  | Jan. 2, 1922  | 43   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |   |
| Laborer   |         |  |   | South Carolina   |   |
| 13. FATHER'S NAME   |         |  | 14. MOTHER'S MAIDEN NAME  |  |   |
| Lattimore Mills   |         |  | Lillie White  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |
| Yes WWII  |         | 213-18-1460  |   | Lillie Alston 2119 St Clair Lane   |   |
| 18. CAUSE OF DEATH  |         |  |   |  | INTERVAL BETWEEN ONSET AND DEATH                          |
| I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |         |  |   |  |   |
| (A) Lobar Pneumonia.<br>DUE TO  |         |  |   |  |   |
| (B) DUE TO  |         |  |   |  |   |
| (C) DUE TO  |         |  |   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |   |  |   |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
|   |         |  |   | Yes  |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
|   |         |  |   |  |   |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?   |   |
| (Month) (Day) (Year) (Hour)   |         | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |   |  |   |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |   |  |   |
| ACTUAL SIGNATURE  |         | M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                          |   |
| EXAMINER'S NAME (Type)  |         | Charles S. Petty, M.D.   |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>           |   |
|   |         |  |   | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>                      |   |
| 23A. BURIAL CREMATION, REMOVAL (Specify)  |         | 23B. DATE  |   | 23C. NAME of CEMETERY or CREMATORY                                       |   |
| Burial  |         | 4/6/65   |   | Balto National Cemetery Balto., Md.                                      |   |
| 24A. DATE REC'D BY HEALTH DEPT.   |         | 24B. NAME OF REGISTRAR   |   | 24C. FUNERAL DIRECTOR ADDRESS  |   |
| APR 8 1965  |         | Robert E. Taylor, M.D.   |   | William C. March 928 E. North  |   |

VALLEY BOULDER

AT BOUNTY

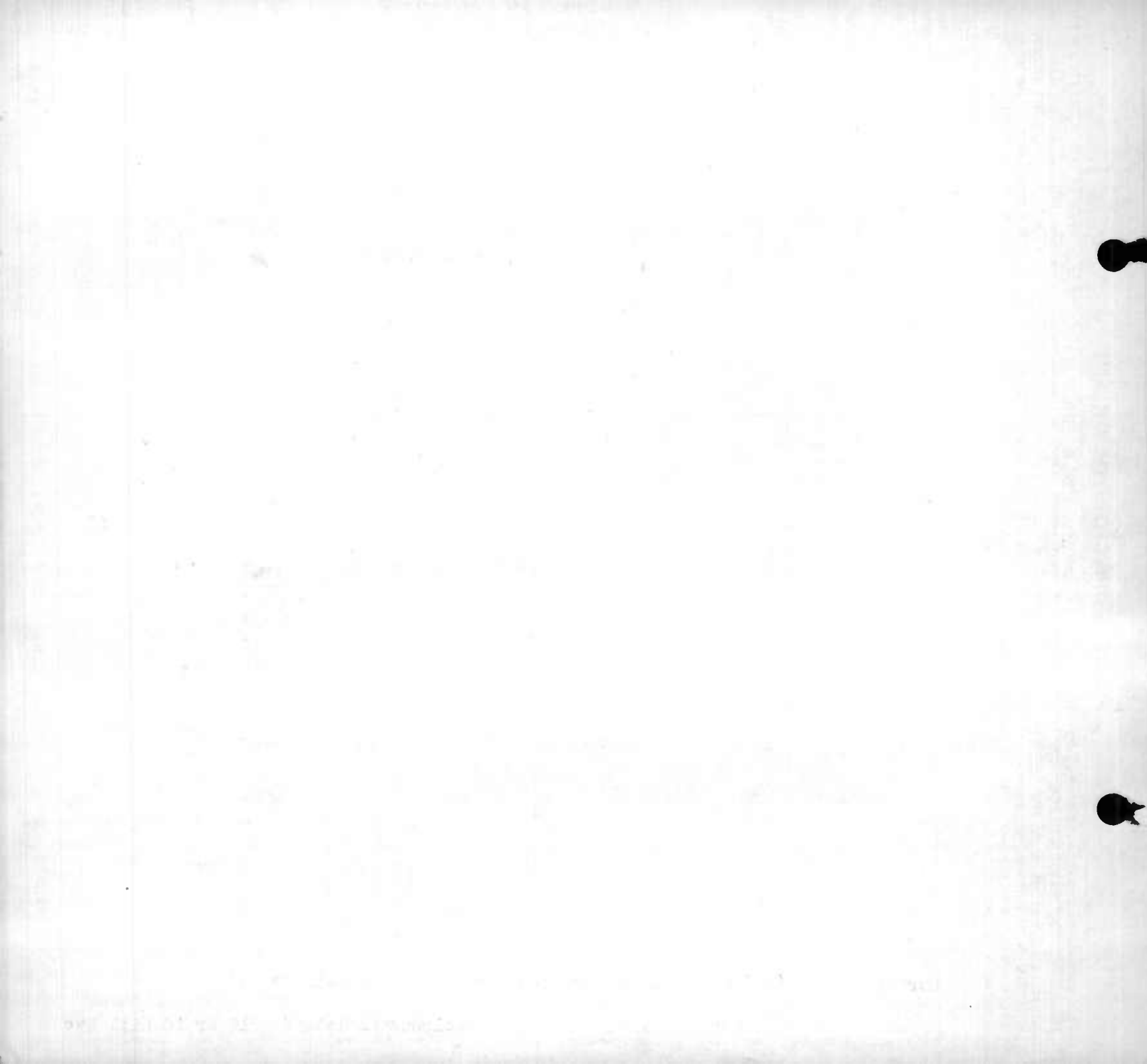
U.S.A.

1977

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

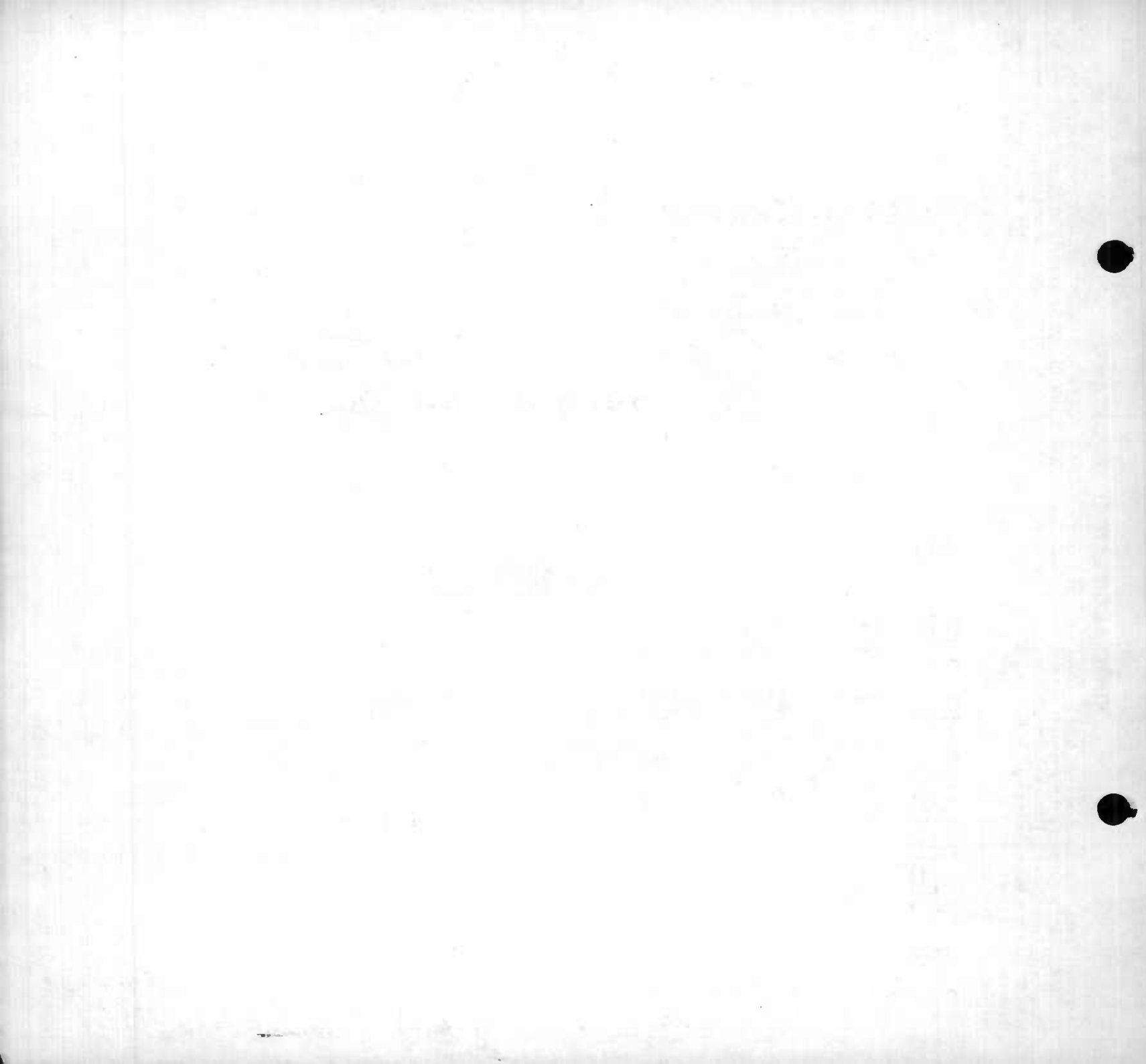
| BIRTH NO. 65 3726  |                         |   |   | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3726   |                       |
|--|-------------------------|---|---|--|--|--|-----------------------|
| M.E. CASE NO.  |                         |   |   | CERTIFICATE OF DEATH   |  |  |                       |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Scott, William</i>   |                         |   |   | 2. DATE AND HOUR OF DEATH<br><i>1:00 April 5, 1965</i> P.M.  |  |  |                       |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                         |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |  |  |                       |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>University Hospital<br/>Baltimore Maryland</i>   |                         |   |   | A. STATE <i>Maryland</i><br>B. COUNTY <i>Hanno</i>   |  |  |                       |
|  |                         |   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>  |  |  |                       |
|  |                         |   |   | D. STREET ADDRESS (If rural, give location)<br><i>1413 M. Iliken Ct</i>  |  |  |                       |
| 5. SEX<br><i>Male</i>  | 6. RACE<br><i>Negro</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>M</i>                                      | 8. DATE OF BIRTH<br><i>Nov 10, 1890</i> | 9. AGE (In years last birthday)<br><i>74</i>   | If Under 1 Yr. Months: Days: Hours: Min. |  | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Not Known</i>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Not Known</i>   |   | 11. BIRTHPLACE (State or foreign country)<br><i>South Carolina</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                           |                       |
| 13. FATHER'S NAME<br><i>Cyrus Scott</i>  |                         |   |   | 14. MOTHER'S MAIDEN NAME<br><i>Emma Evans</i>  |  |  |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>Unknown</i>   |                         | 16. SOCIAL SECURITY NO.<br><i>Unknown</i>   |   | 17. INFORMANT<br><i>Wife</i>   |  | ADDRESS  |                       |
| 18. <i>420.01</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><i>Unknown</i>   |                         |   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |  |                       |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><i>Unknown</i>   |                         |   |   | <i>Unknown</i>   |  |  |                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Chronic brain syndrome</i>  |                         |   |   | <i>2 years</i>   |  |  |                       |
| 19A. DATE OF OPERATION<br><i>2</i>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><i>Yes</i>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |                       |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |                       |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 28, 1965</i> to <i>April 5, 1965</i> , that (I) (we) last saw the deceased alive on <i>April 5, 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |   |  |  |  |                       |
| 23A. SIGNATURE<br><i>Harold C. Standiford</i>  |                         |   |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><i>April 5, 1965</i>                             |                       |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Harold C. Standiford</i>  |                         |   |   | 23D. ADDRESS<br><i>University Hospital</i>   |  |  |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 24B. DATE<br><i>4/10/65</i>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><i>Mt. Auburn Cemetery</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md</i> |                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 8 1965</i>   |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Bailey</i>   |   | 25C. FUNERAL DIRECTOR<br><i>Adolphus Halstead</i>  |  |  |                       |
|  |                         |   |   | ADDRESS<br><i>918 Druid Hill Ave</i>   |  |  |                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |         |  |                  |  |   |
|---|---------|--|------------------|--|---|
| BIRTH NO. 65 3727   |         | BALTIMORE CITY HEALTH DEPARTMENT   |                  | Registered No. 65 3727   |   |
| M.E. CASE NO.   |         | 1. NAME OF DECEASED (Type or Print)  |                  | 2. DATE AND HOUR OF DEATH  |   |
| 1. NAME OF DECEASED (Type or Print)   |         | Frank Becker PUNEVICIUS  |                  | 4/7/65 8:45 a.m.   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |                  | 5. COUNTY  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                                |                  | D. STREET ADDRESS (If rural, give location)                              |   |
| 1327 W. Lombard St.   |         | Ind. Baltimore   |                  | 1327 W. Lombard St.  |   |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. Under 1 Yr. Months: Days: Hours: Min. |
| male  | white   | married  | 5-1-97           | 67   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |   |
| Crane Operator Ind. Steel   |         | Ind. Steel   |                  | Ind.   |   |
| 13. FATHER'S NAME   |         | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| Anthony Pukewicius  |         | Mary Tarasewicz  |                  | U. S. A.   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |   |
| yes WWI   |         | 216070568  |                  | Mrs. Mary Becker - Above   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |         | CAUSE OF DEATH   |                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 154X I  |         | Ca of the rectum   |                  |  |   |
| ANTECEDENT CAUSES   |         | DUE TO   |                  |  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         | DUE TO   |                  |  |   |
| II  |         | DUE TO   |                  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |                  |  |   |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |   |
| 0   |         |  |                  | no   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 1964 to April 7 1965, that (I) (we) last saw the deceased alive on 4. 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |  |   |
| 23A. SIGNATURE  |         | 23B. DATE SIGNED   |                  |  |   |
| Stanley Ankudas M.D.  |         | 4. 7. 65   |                  |  |   |
| 23C. PHYSICIAN'S NAME (Type)  |         | 23D. ADDRESS   |                  |  |   |
| STANLEY ANKUDAS M.D.  |         | 1803 W. Baltimore, Baltimore 23md  |                  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |   |
| Burial  |         | 4/10/65  |                  | Maryland New Park Cem.   |   |
| 24D. LOCATION (City, town, or county) (State)   |         | 24E. DATE REC'D BY HEALTH DEPT.  |                  | 24F. NAME OF REGISTRAR   |   |
| 2901 Taylor Ave Parkville Md.   |         | APR 8 1965   |                  | Robert E. Taylor   |   |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS  |   |
| APR 8 1965  |         | Robert E. Taylor   |                  | Joseph J. Gowan & Son Inc. 33 Hollis 23, Md.                             |   |

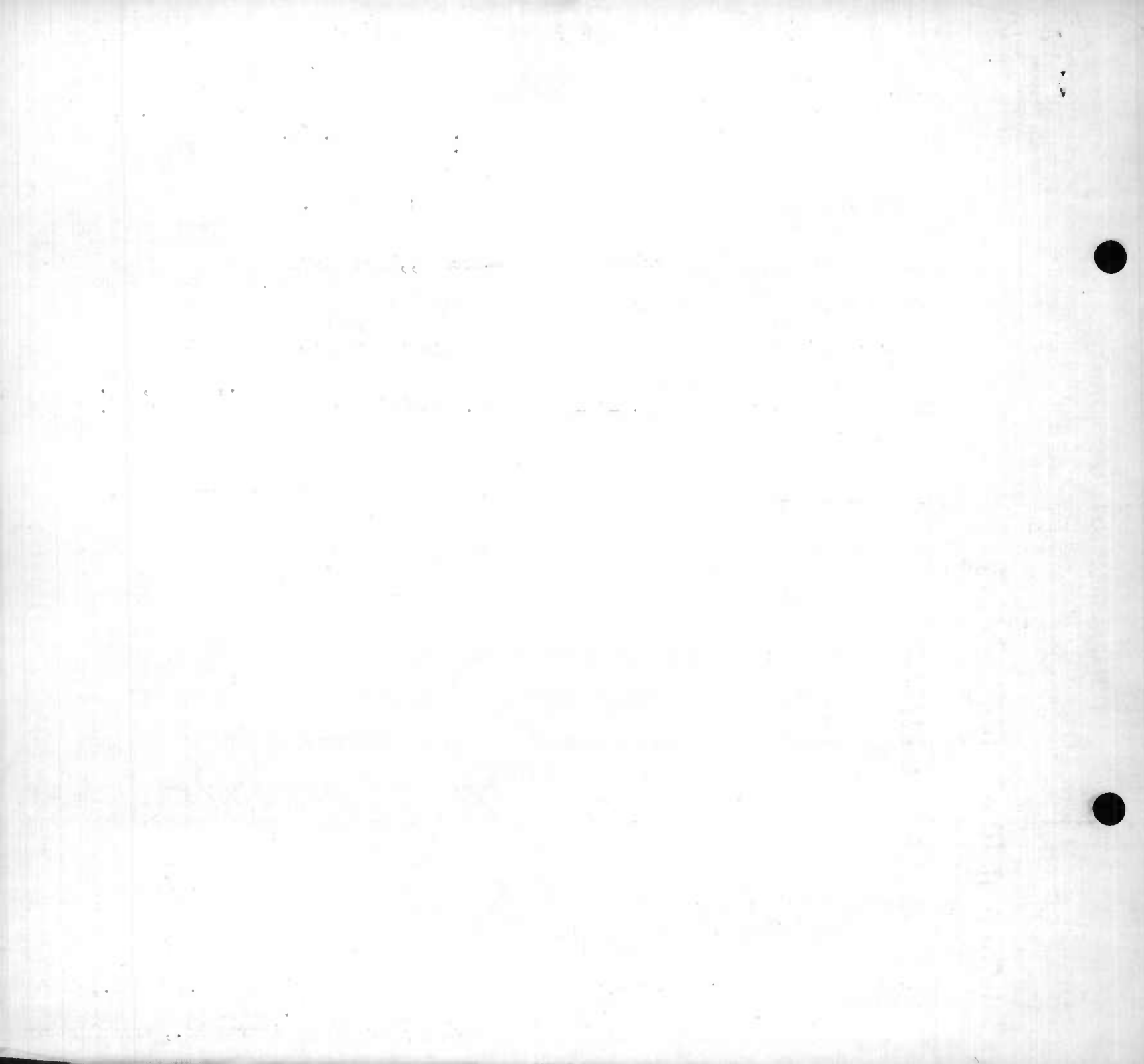




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |              |   |   | Registered No. 65 3728   |  |
|---|--------------|---|---|--|--|
| BIRTH NO. 65 3728   |              | <b>CERTIFICATE OF DEATH</b>   |   |  |  |
| M.E. CASE NO.   |              | 1. NAME OF DECEASED<br>(Type or Print) CREMEN, ELIZABETH  |   | 2. DATE AND HOUR OF DEATH<br>4/5/65 1:30 A. M.                           |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                     |   | 5. COUNTY  |  |
| FULL NAME OF INSTITUTION<br>SINAI HOSPITAL  |              | (If not in hospital or institution, give street address or location)                                      |   | Md. Balto. Co.   |  |
|   |              | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                                   |   | Pikerville 53-00   |  |
|   |              | D. STREET ADDRESS (If rural, give location)   |   | 109 Old Court Rd.  |  |
| 5. SEX<br>female  | 6. RACE<br>w | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>married                                       | 8. DATE OF BIRTH<br>March 28, 1908                      | 9. AGE (In years last birthday)<br>57                                    | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>sales lady |
|   |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>bakery dept  | 11. BIRTHPLACE (State or foreign country)<br>Balto      |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |
| 13. FATHER'S NAME<br>Fredrick Thiele  |              |   | 14. MOTHER'S MAIDEN NAME<br>Minnie Wilhelm              |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>no   |              | 16. SOCIAL SECURITY NO.<br>218-22-2076  | 17. INFORMANT<br>Mrs. Patricia Graham 109 Old court Rd. |  |  |
|   |              | 18. CAUSE OF DEATH  |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              | (A) Hepatic coma<br>DUE TO<br>(B) Liver cirrhosis<br>DUE TO<br>(C)  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |              |   |   |  |  |
| 19A. DATE OF OPERATION  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)   |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3/31 1965 to 4/5 1965, that (I) (we) lost saw the deceased alive on 4/5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                         |              |   |   |  |  |
| 23A. SIGNATURE<br>Gerardo M. Ypil Jr.   |              |   |   | 23B. DATE SIGNED<br>4/5/65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>GERARDO M. YPIL JR. M.D.  |              |   |   | 23D. ADDRESS<br>SINAI HOSPITAL   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>burial  |              | 24B. DATE<br>April 8, 1965  |   | 24C. NAME of CEMETERY or CREMATORY<br>Druid Ridge Cem                    |  |
|   |              | 24D. LOCATION (City, town, or county) (State)<br>Park Heights Ave., Balto., 21208                         |   |  |  |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br>APR 8 1965  |              | 25B. NAME OF REGISTRAR<br>Robert E. Taylor M.D.   |   | 25C. FUNERAL DIRECTOR<br>Loring Byers 8728 Liberty Rd., Randallstown     |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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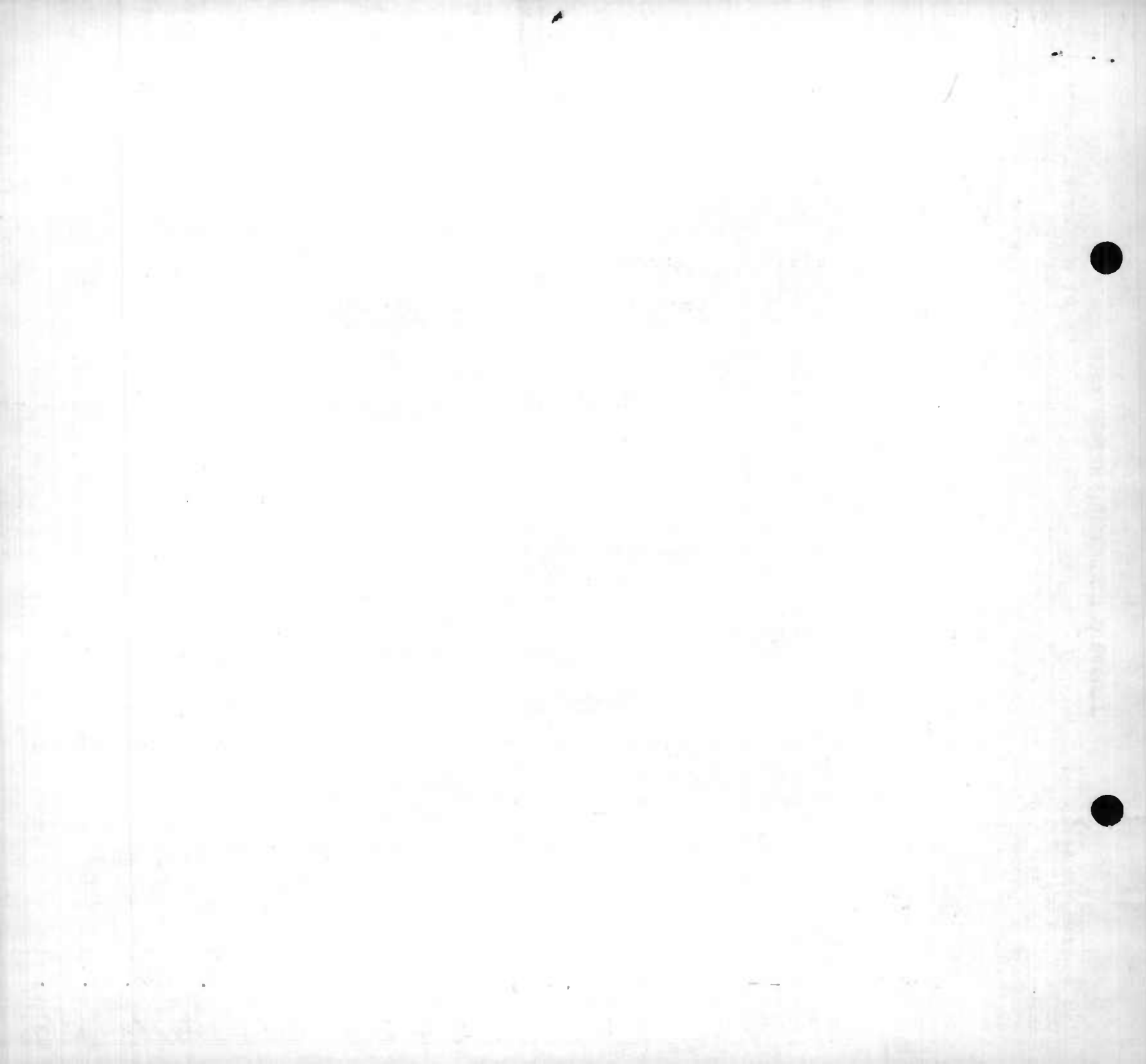
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

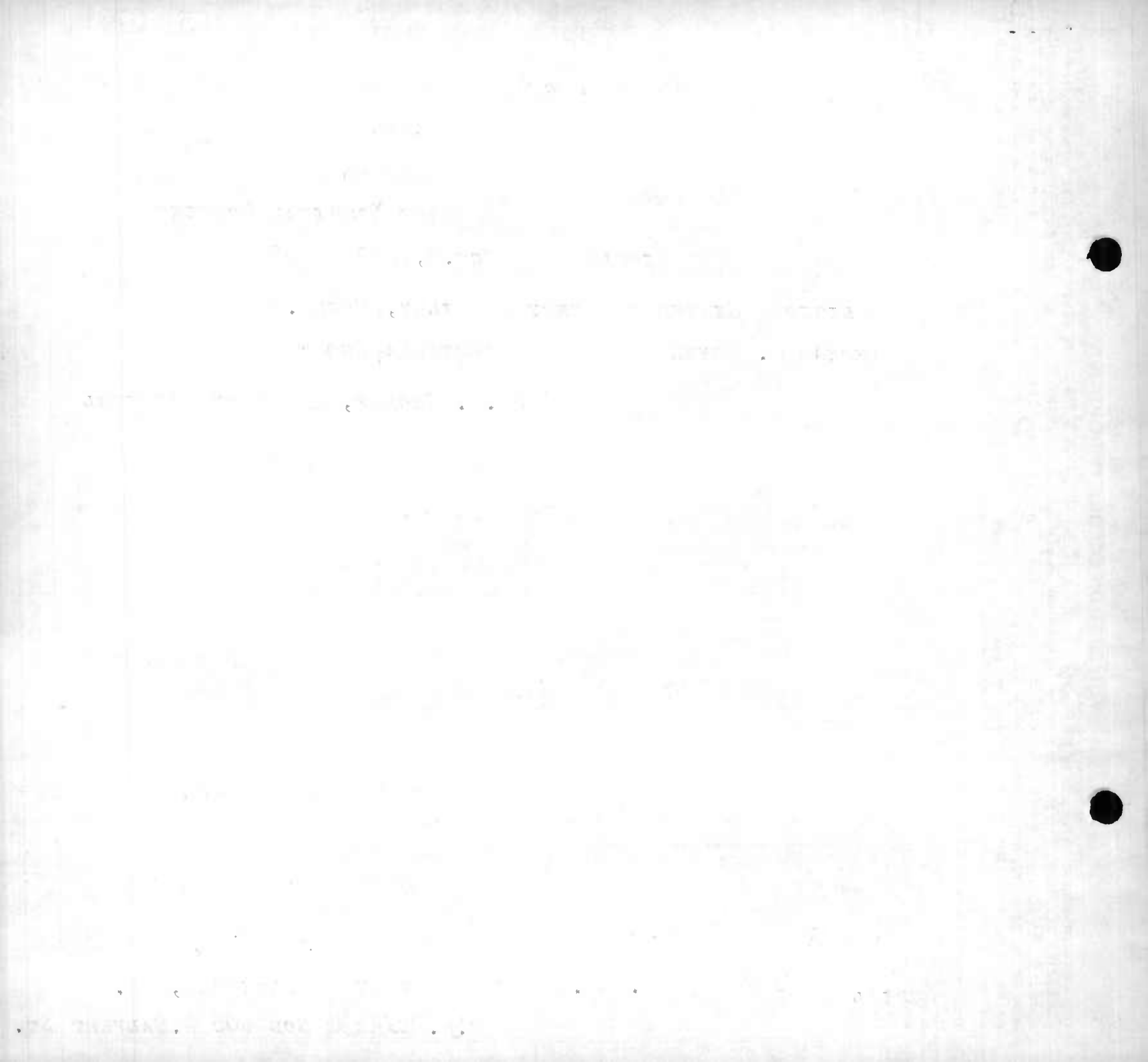
| BIRTH NO. 65 3730  |                         |   |                                   | BALTIMORE CITY HEALTH DEPARTMENT  |   | Registered No. 65 3730  |  |
|--|-------------------------|---|-----------------------------------|---|---|---|--|
| M.E. CASE NO.  |                         |   |                                   | CERTIFICATE OF DEATH  |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MADL, LOUIS</b>  |                         |   |                                   | 2. DATE AND HOUR OF DEATH<br><b>4/5/65 3:40 P. M.</b>   |   |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>MARYLAND GENERAL HOSP.<br/>827 LINDEN AVE<br/>BALTO., MD.</b>  |                         |   |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>Balt</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 53-00</b><br>D. STREET ADDRESS (If rural, give location) <b>7101 BROMPTON RD.</b> |   |   |  |
| 5. SEX<br><b>male</b>  | 6. RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>married</b>                                  | 8. DATE OF BIRTH<br><b>7/6/89</b> | 9. AGE (In years lost birthday)<br><b>75</b>  | 10. Under 1 Yr. Months: Days: Hours: Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Carpenter</b>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>GERMANY</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>LOUIS MADL</b>   |                         |   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>KATHERINE MYERS</b>  |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>212 01 9218</b>   |                                   | 17. INFORMANT ADDRESS<br><b>MARYLAND GEN. HOSP. 827 LINDEN AVE</b>  |   |   |  |
| 18. <b>334X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>CEREBRAL VASC. DISEASE</b><br>DUE TO<br>(B) _____<br>DUE TO<br>(C) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |   |                                   | INTERVAL BETWEEN ONSET AND DEATH  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |   |                                   |   |   |   |  |
| 19A. DATE OF OPERATION<br><b>3/22</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                   | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/22</b> 19 <b>65</b> to <b>4/5</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |                                   |   |   |   |  |
| 23A. SIGNATURE<br><b>Pietro Lustrucci</b>  |                         |   |                                   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |   | 23B. DATE SIGNED<br><b>4/5/65</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>LASTRUCCI PIETRO</b>  |                         |   |                                   | 23D. ADDRESS<br><b>MARYLAND GEN. HOSP.</b>  |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                         | 24B. DATE<br><b>4-8-1965</b>  |                                   | 24C. NAME of CEMETERY or CREMATORY<br><b>Lorrain Pk. Cem,</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Windsor Mill Rd. Balto. Co. Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Staley</b>   |                                   | 25C. FUNERAL DIRECTOR<br><b>John J. Bane</b>  |   | 25D. ADDRESS<br><b>8728 Liberty Rd. Randalltown</b>                                     |  |



# FUNERAL DIRECTOR: IMPORTANT

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|  |                      |  |                                  |  |   |
|--|----------------------|--|----------------------------------|--|---|
| BIRTH NO. 65 3731  |                      | BALTIMORE CITY HEALTH DEPARTMENT   |                                  | Registered No. 65 3731   |   |
| M.E. CASE NO.  |                      | CERTIFICATE OF DEATH   |                                  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br>SR. MARY De PAUL - BORN - MARIAN MOYER   |                      | 2. DATE AND HOUR OF DEATH<br>4-7-65 4:30 AM.   |                                  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY<br>MARYLAND              |                                  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br>Mercy Hospital.  |                      | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE 04-01   |                                  |  |   |
|  |                      | D. STREET ADDRESS (If rural, give location)<br>MERCY HOSPITAL CONVENT  |                                  |  |   |
| 5. SEX<br>F  | 6. RACE<br>W         | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br>SINGLE   | 8. DATE OF BIRTH<br>Oct. 2, 1907 | 9. AGE (In years last birthday)<br>57                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RELIGIOUS SISTER OF MERCY   |                      | 10B. KIND OF BUSINESS OR INDUSTRY  |                                  | 11. BIRTHPLACE (State or foreign country)<br>LILLY, PENNA.               |   |
| 13. FATHER'S NAME<br>THOMAS J. MOYER   |                      | 14. MOTHER'S MAIDEN NAME<br>ESTELLA SHORT  |                                  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                      | 16. SOCIAL SECURITY NO.  |                                  | 17. INFORMANT<br>SR. M. THOMAS, RSM MERCY HOSPITAL                       |   |
| 18. 360.41<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                      | CAUSE OF DEATH<br>(A) Cardiac Arrest<br>DUE TO<br>(B) Electrolyte Imbalance<br>DUE TO<br>(C) Nephritis + Left sub-phrenic Abscess    |                                  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| 19A. DATE OF OPERATION<br>3-16-65  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Hernia   |                                  | 20A. AUTOPSY? (Yes or No)<br>YES   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                                  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from MARCH 15 19 65 to APRIL 7 19 65, that (I) (we) last saw the deceased alive on APRIL 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) not view the body after death.   |                      |  |                                  |  |   |
| 23A. SIGNATURE<br>Frank L. Barham  |                      | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                  | 23B. DATE SIGNED<br>3-7-65   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>FRANK L. BARHAM  |                      | 23D. ADDRESS<br>Mercy Hosp. Balto., Md.  |                                  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE<br>4/10/65 | 24C. NAME of CEMETERY or CREMATORY<br>Mt. St. AGNES CEMETERY   |                                  | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE, MD.          |   |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br>APR 8 1965   |                      | 25B. NAME OF REGISTRAR<br>R. E. Staley, M.D.   |                                  | 25C. FUNERAL DIRECTOR<br>H. W. NEARS & SON 805 N. CALVERT ST.            |   |

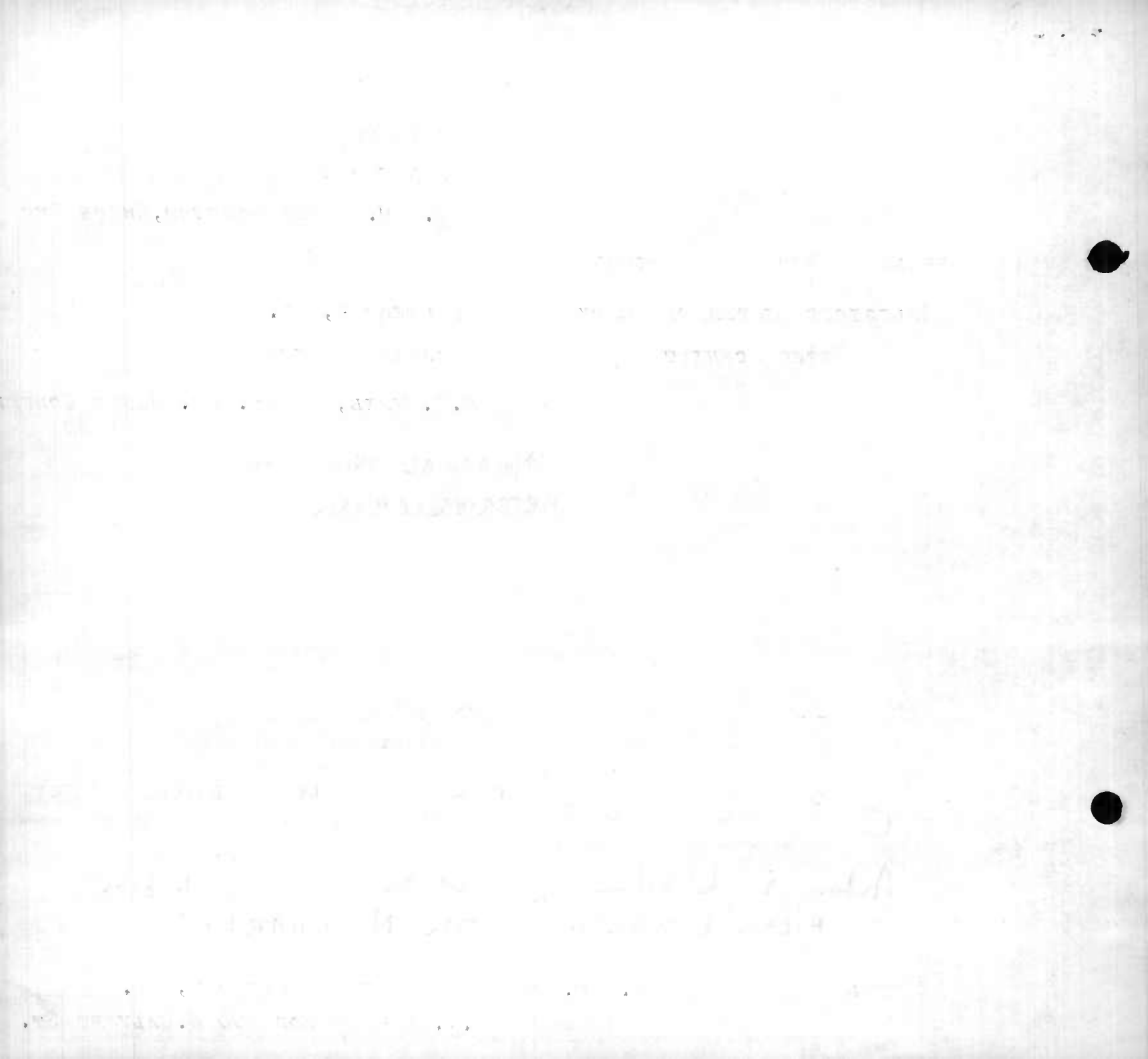




# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                         |  |                                    | BIRTH NO. 65 3732   |   | CERTIFICATE OF DEATH   |                              | Registered No. 65 3732           |         |  |
|--|-------------------------|--|------------------------------------|---|---|--|------------------------------|----------------------------------|---------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Sister Mary Callista Schmidt (RSM)</i>   |                         |  |                                    | 2. DATE AND HOUR OF DEATH<br><i>4/5/65</i>  |   | M. <i>6 30 PM</i>  |                              |                                  |         |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Mt St Agnes<br/>Mt Washington<br/>Baltimore Md</i>   |                         |  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>MARYLAND</i><br>B. COUNTY<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>BALTIMORE</i><br>D. STREET ADDRESS (If rural, give location)<br><i>Mt. St. Agnes Convent, SMITH AVE</i> |   |  |                              |                                  |         |  |
| 5. SEX<br><i>FEMALE</i>  | 6. RACE<br><i>WHITE</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>SINGLE</i>                              | 8. DATE OF BIRTH<br><i>3-2-'79</i> | 9. AGE (In years lost birthday)<br><i>86</i>  | If Under 1 Yr. Months: Days: Hours: Min.                        |  | 12. CITIZEN OF WHAT COUNTRY? |                                  |         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>RELIGIOUS SISTER OF MERCY</i>  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY  |   |   | 11. BIRTHPLACE (State or foreign country)<br><i>BALTIMORE, MD.</i>     |                              | 12. CITIZEN OF WHAT COUNTRY?     |         |  |
| 13. FATHER'S NAME<br><i>PETER SCHMIDT</i>  |                         |  |                                    | 14. MOTHER'S MAIDEN NAME<br><i>MARGARET RICE</i>  |   |  |                              |                                  |         |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                         |  | 16. SOCIAL SECURITY NO.            |   | 17. INFORMANT<br><i>SR. M. CYRIL, RSM Mt. St. Agnes Convent</i> |  |                              |                                  | ADDRESS |  |
| 18. <i>4-20-1 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>MYOCARDIAL INFARCTION<br/>ARTERIOSCLEROSIS</i><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |  |                                    | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C)   |   |  |                              | INTERVAL BETWEEN ONSET AND DEATH |         |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |                                    |   |   |  |                              |                                  |         |  |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                              |                                  |         |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |                              |                                  |         |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?  |   |  |                              |                                  |         |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>FEB 19 65</i> to <i>APRIL 19 65</i> , that (I) (we) last saw the deceased alive on <i>4-5-65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |  |                                    |   |   |  |                              |                                  |         |  |
| 23A. SIGNATURE<br><i>Aidan E. Walsh</i>  |                         |  |                                    | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |   | 23B. DATE SIGNED<br><i>4-6-65</i>                                      |                              |                                  |         |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>AIDAN E. WALSH</i>  |                         |  |                                    | 23D. ADDRESS<br><i>715 N. CHARLES</i>   |   |  |                              |                                  |         |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |                         | 24B. DATE<br><i>4/8/65</i>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><i>Mt. St. Agnes Cemetery</i>   |   | 24D. LOCATION (City, town, or county) (State)<br><i>BALTIMORE, MD.</i> |                              |                                  |         |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 8 1965</i>   |                         | 25B. NAME OF REGISTRAR<br><i>R. G. E. Farley</i>   |                                    | 25C. FUNERAL DIRECTOR<br><i>H. W. MEARS &amp; SON</i>   |   | ADDRESS<br><i>805 N. CALVERT ST.</i>                                   |                              |                                  |         |  |



1-600

65 3733

BALTIMORE CITY HEALTH DEPARTMENT

65 3733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

MYRTLE LURIE

2. DATE AND HOUR PRONOUNCED DEAD

April 5, 1965

2:30 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1630 Forest Hill Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

Sept 1, 1910

9. AGE (In years  
last birthday)

54

10. If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Domestic

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

13. FATHER'S NAME

Edward Adams

14. MOTHER'S MAIDEN NAME

Lillie Mansdon

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

None

17. INFORMANT

ADDRESS

Jack Lurie 1630 Forest Hill Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

(A) Fatty metamorphosis of the liver  
DUE TO with advanced cirrhosis

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK

NOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-9-65

23C. NAME of CEMETERY or CREMATORY

London Park

23D. LOCATION

(City, town, or county)

BALTIMORE, Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 8 1965

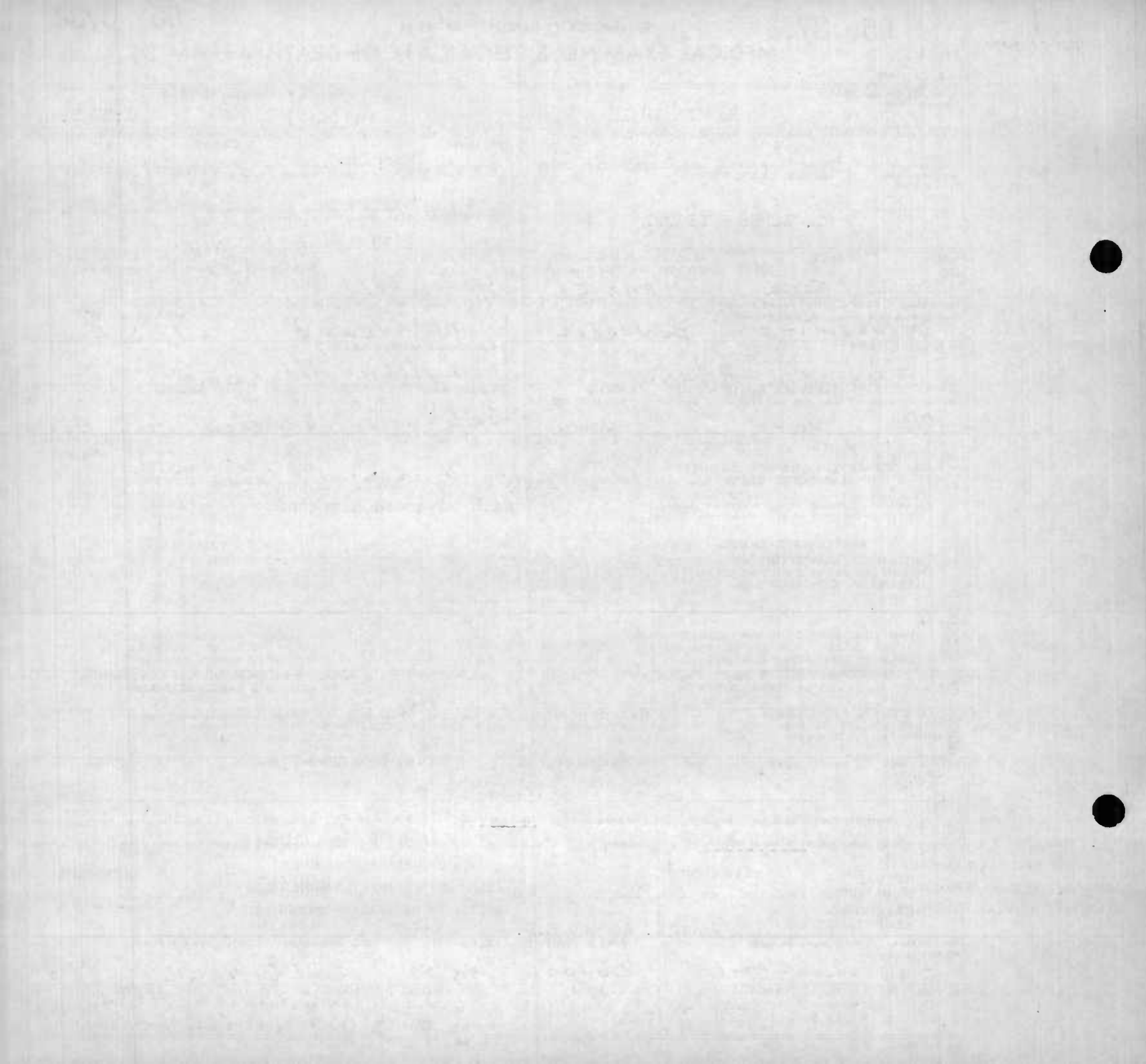
24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Geo. L. Schwab Funeral Home  
2101 Frederick Ave.

ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| BIRTH NO. 65 3734  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3734   |  |
| M.E. CASE NO.  |  | CERTIFICATE OF DEATH  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>EDWARD F. CLANCY</b>   |  |
| 2. DATE AND HOUR OF DEATH<br><b>4/5/65</b>   |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><b>CERTIFICATE CORRECTED 4-21-65</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Mo.</b> B. COUNTY <b>49</b> |  |
| 5. SEX <b>M.</b> 6. RACE <b>W</b>  |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>WIDOWER</b>  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Belvedere Beach 5200</b>                           |  |
| 8. DATE OF BIRTH <b>1901</b>   |  | 9. AGE (In years lost birthday) <b>63</b>   |  | D. STREET ADDRESS (If rural, give location)<br><b>—</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>STATE</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTO.</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  | 13. FATHER'S NAME<br><b>James Clancy</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>BRIDGITT ?</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>—</b>   |  | 16. SOCIAL SECURITY NO.<br><b>47-098-7444</b>   |  | 17. INFORMANT<br><b>Son</b> ADDRESS <b>Same</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocardial infarction</b>   |  | 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b> |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  | 21. DATE OF OPERATION   |  | 22. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 23. DATE OF OPERATION  |  | 24. AUTOPSY? (Yes or No)<br><b>No</b>   |  | 25. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 26. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 27. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 28. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 30. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 31. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>2-21-</b> 19 <b>65</b> to <b>4-5-</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-5-</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>G. R. Sadjadi</b>   |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>            |  | 23B. DATE SIGNED<br><b>4-6-65</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>G. R. SADJADI</b>   |  | 23D. ADDRESS<br>M.D. <b>5829 Belair Rd. Balto. Md. 21206</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>4/8/65</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Immanuel Cem</b>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO Mo</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |  | 25B. NAME OF REGISTRAR<br><b>Paul E. Talley M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>P. A. Heermann</b>   |  | ADDRESS<br><b>6067 HARFORD RD</b>   |  |  |  |

The approval of Medical Examiner By

V.S. 153

4-21-65

M.H.



1  
H 200

65 3735

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 3735

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE H. HAAS

2. DATE AND HOUR PRONOUNCED DEAD

April 5, 1965

9:45 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

BALTIMORE CITY HOSPITALS

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1517 S. Clinton Street

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

NEVER MARRIED

8. DATE OF BIRTH

FEB. 21, 1913

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LONG SHOREMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MD.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

WILLIAM HAAS

14. MOTHER'S MAIDEN NAME

LULA YEAGER

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

YES

WW2

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

LULA HOFFMAN 1517 S. CLINTON ST.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular  
DUE TO disease

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK

NOT WHILE  
AT WORK

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

APR. 9, 1965

23C. NAME OF CEMETERY or CREMATORY

OAK LAWN

23D. LOCATION

(City, town, or county)

BALTO. Co.

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 8 1965

24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Georg Hoffmann 3218 HUDSON ST.

ADDRESS



VALLEY FORCE

WEEK ENDING FEB. 1913

MD.

LEWIS YEAGER

LEWIS HATTMAN 1912-1913

LEWIS HATTMAN 1912-1913

LEWIS HATTMAN 1912-1913



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3736   |                         |  |   | BALTIMORE CITY HEALTH DEPARTMENT  |   | Registered No. 65 3736  |   |
|---|-------------------------|--|---|---|---|---|---|
| M.E. CASE NO.   |                         |  |   | CERTIFICATE OF DEATH  |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ARTHUR JOHNSON</b>  |                         |  |   | 2. DATE AND HOUR OF DEATH<br><b>4-2-65 8 AM</b>   |   |   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                     |   |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MERCY HOSP. INC.</b>   |                         | (If not in hospital or institution, give street address or location)<br><b>BALTO., MD.</b>             |   | A. STATE<br><b>MARYLAND</b>   |   | B. COUNTY<br><b>1204</b>  |   |
|   |                         |  |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>                               |   |   |   |
|   |                         |  |   | D. STREET ADDRESS (If rural, give location)<br><b>2000 BARCLAY ST.</b>  |   |   |   |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>Negro</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                             | 8. DATE OF BIRTH<br><b>2-10-1899</b>          | 9. AGE (In years lost birthday)<br><b>66</b>  | If Under 1 Yr. Months Days  | If Under 24 Hrs. Hours Min.   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>   |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY             |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>   |                         |  |   | 14. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>  |   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         |  | 16. SOCIAL SECURITY NO.<br><b>071-03-2789</b> |   | 17. INFORMANT<br><b>C. Johnson</b>                                      |   | ADDRESS<br><b>Philadelphia, Pa.</b>           |
| 18. <b>153.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>UREMIA</b>  |                         |  |   | CAUSE OF DEATH  |   | INTERVAL BETWEEN ONSET AND DEATH  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |  |   | (B) <b>METASTATIC DISEASE</b>   |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |   |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3-2-65</b> 19 to <b>4-2</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-2</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |   |   |   |   |   |
| 23A. SIGNATURE<br><b>Manuel A. Thomas</b>   |                         |  |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |   | 23B. DATE SIGNED  |   |
| 23C. PHYSICIAN'S NAME (Type)  |                         |  |   | 23D. ADDRESS<br>M.D.  |   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4-7-65</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Int. Calvary Cemetery</b>  |   | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. A.A. County Maryland</b> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Thompson + Dyett Fun'l Home 916 Penna</b>   |   |   |   |

Cause of Death - Generalized Metastases  
Carcinoma Ascending Letter  
Information from query letter to Henry Hospital  
Filed in Doc't file - Bur. of Biostatistics - American Bldg.  
3/4/65 Jc

1  
5.530

65 3737

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 3737

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

GEORGE R. SMITH

2. DATE AND HOUR PRONOUNCED DEAD

April 2, 1965

4:00 p

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

925 Argyle Avenue

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

925 Argyle Avenue

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Single

8. DATE OF BIRTH

6-6-1915

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unemployed

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Hereford, Md

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

George Smith

14. MOTHER'S MAIDEN NAME

Amelia Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

UNK

17. INFORMANT

ADDRESS

Leroy Smith - 935 Argyle

1B.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) Chronic lung disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Epilepsy by history

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐

M.D. ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-3-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-7-65

23C. NAME of CEMETERY or CREMATORY

MT CALVARY

23D. LOCATION

(City, town, or county)

A.A. Co.

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 8 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Norton & Dye H 916 Penna Ave.

VALLEY FORD

APR 10 1964

## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 3738 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3738

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WALTER A. FOUNTAIN III

2. DATE AND HOUR PRONOUNCED DEAD

4-5-65

7:10P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

ST. AGNES HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

716 Eastshire Drive 20228

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

single

8. DATE OF BIRTH

August 30, 1956

9. AGE (In years  
last birthday)

8

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

none

10B. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

Walter A. Fountain Jr.

14. MOTHER'S MAIDEN NAME

Marian Abbott

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

none

17. INFORMANT

ADDRESS

Walter A. Fountain Jr. 716 Eastshire Dr

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osteoporosis, etc. It means the disease,  
injury or complication which caused death.)(A) Cranio-cerebral injury  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B)  
DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

X

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

X

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR?

In front of Bloomsbury Ave.,

Baltimore County

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 2 '65 7:55  
p m.

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Bicyclist - Struck

by auto.

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

April 8, 1965

23C. NAME of CEMETERY or CREMATORY

Balto. National Cem

23D. LOCATION

(City, town, or county)

Balto., Maryland

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 8 1965

24B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

24C. FUNERAL DIRECTOR

Sterling Funeral Estate 736 Edm. Av  
Catonsville,

ADDRESS

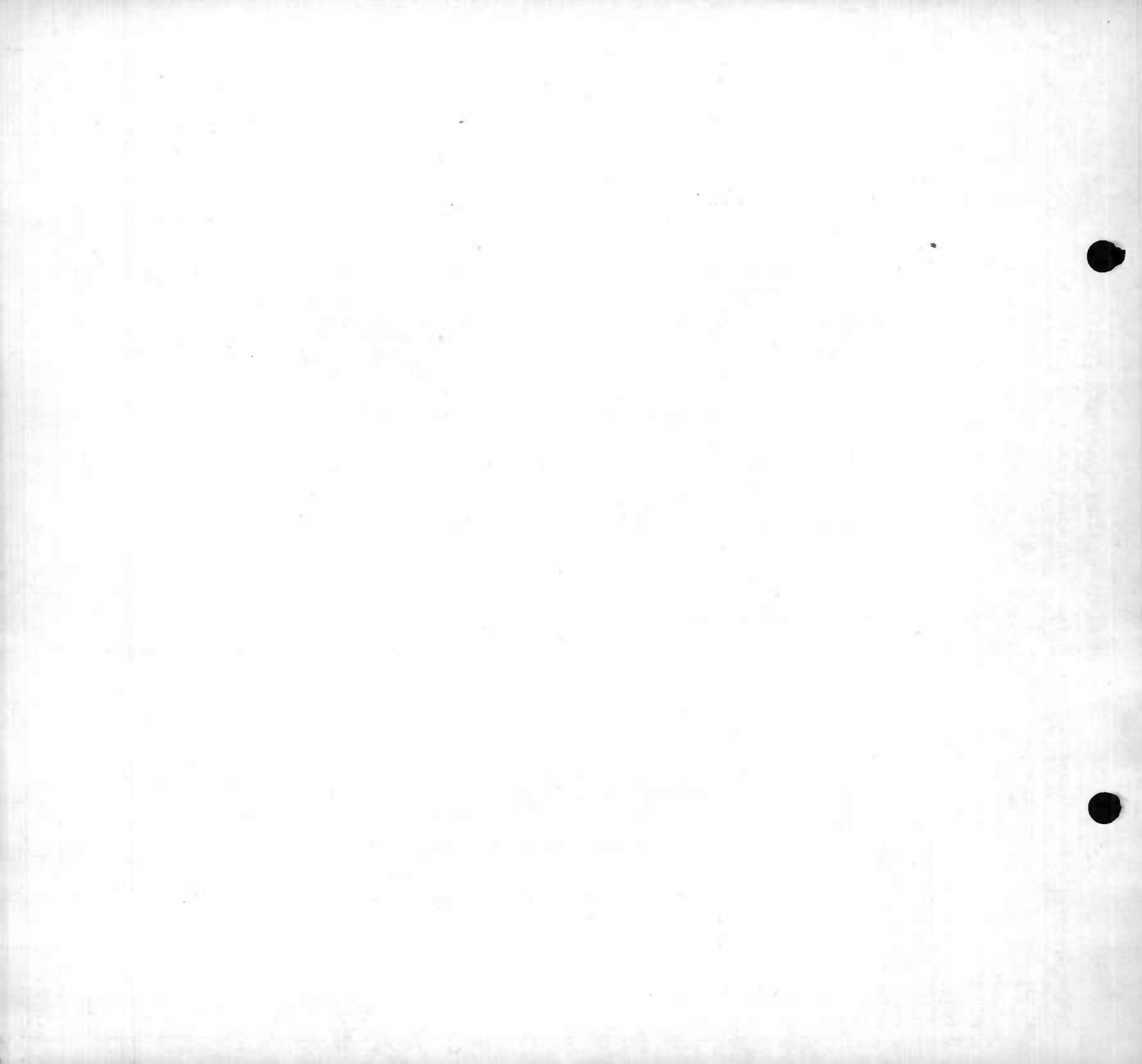
10/10/10



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |  |                                    | BIRTH NO. 65-07885 65 3739   |                            | CERTIFICATE OF DEATH   |                             | Registered No. 65 3739   |  |
|--|---------------------|--|------------------------------------|--|----------------------------|--|-----------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <i>Cicero, Baby, Boy</i>  |                     |  |                                    | 2. DATE AND HOUR OF DEATH<br><i>3/29/65 4:50 A.M.</i>  |                            |  |                             |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Mercy Hospital.</i>  |                     |  |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY <i>27-19</i><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore 15</i><br>D. STREET ADDRESS (If rural, give location)<br><i>4004 W. Rodgers Ave</i> |                            |  |                             |  |  |
| 5. SEX<br><i>M</i>   | 6. RACE<br><i>W</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH<br><i>3-29-65</i> | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                     | 10B. KIND OF BUSINESS OR INDUSTRY  |                                    | 11. BIRTHPLACE (State or foreign country)  |                            | 12. CITIZEN OF WHAT COUNTRY?   |                             |  |  |
| 13. FATHER'S NAME<br><i>Pasquale Cicero</i>  |                     |  |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Theresa Greco</i>   |                            |  |                             |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                     |  |                                    | 16. SOCIAL SECURITY NO.  |                            | 17. INFORMANT ADDRESS<br><i>Hospital</i>                               |                             |  |  |
| 18. <i>776X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |  |                                    | CAUSE OF DEATH<br>(A) DUE TO <i>Immaturity</i><br>(B) DUE TO<br>(C)  |                            | INTERVAL BETWEEN ONSET AND DEATH<br><i>Life</i>                        |                             |  |  |
| MEDICAL CERTIFICATION  |                     |  |                                    |  |                            |  |                             |  |  |
| 19. DATE OF OPERATION<br><i>0</i>  |                     |  |                                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            | 20A. AUTOPSY? (Yes or No)  |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |  |                             |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?   |                            |  |                             |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> , that (I) (we) lost saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                     |  |                                    |  |                            |  |                             |  |  |
| 23A. SIGNATURE<br><i>W. E. Standiford</i>  |                     |  |                                    | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                            | 23B. DATE SIGNED<br><i>3/24/65</i>                                     |                             |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Willard E. Standiford</i>   |                     |  |                                    | 23D. ADDRESS   |                            |  |                             |  |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><i>Burial</i>   |                     | 24B. DATE<br><i>March 30 1965</i>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><i>New Cathedral Cemetery</i>  |                            | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i> |                             |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 8 1965</i>   |                     | 25B. NAME OF REGISTRAR<br><i>R. E. Taylor M.D.</i>   |                                    | 25C. FUNERAL DIRECTOR<br><i>Frank J. Howell</i>  |                            | 25D. ADDRESS<br><i>Baltimore, Md.</i>                                  |                             |  |  |

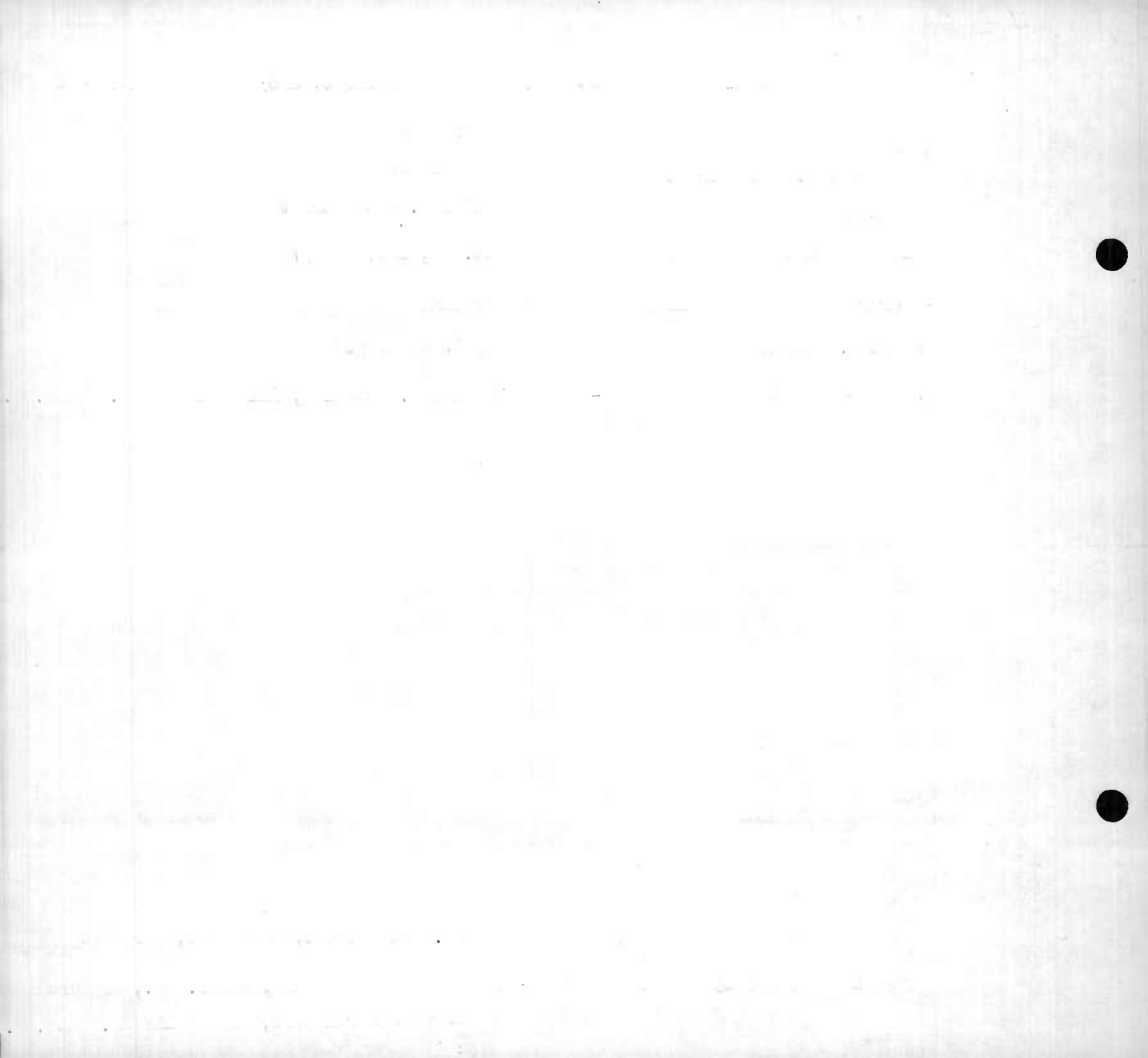




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

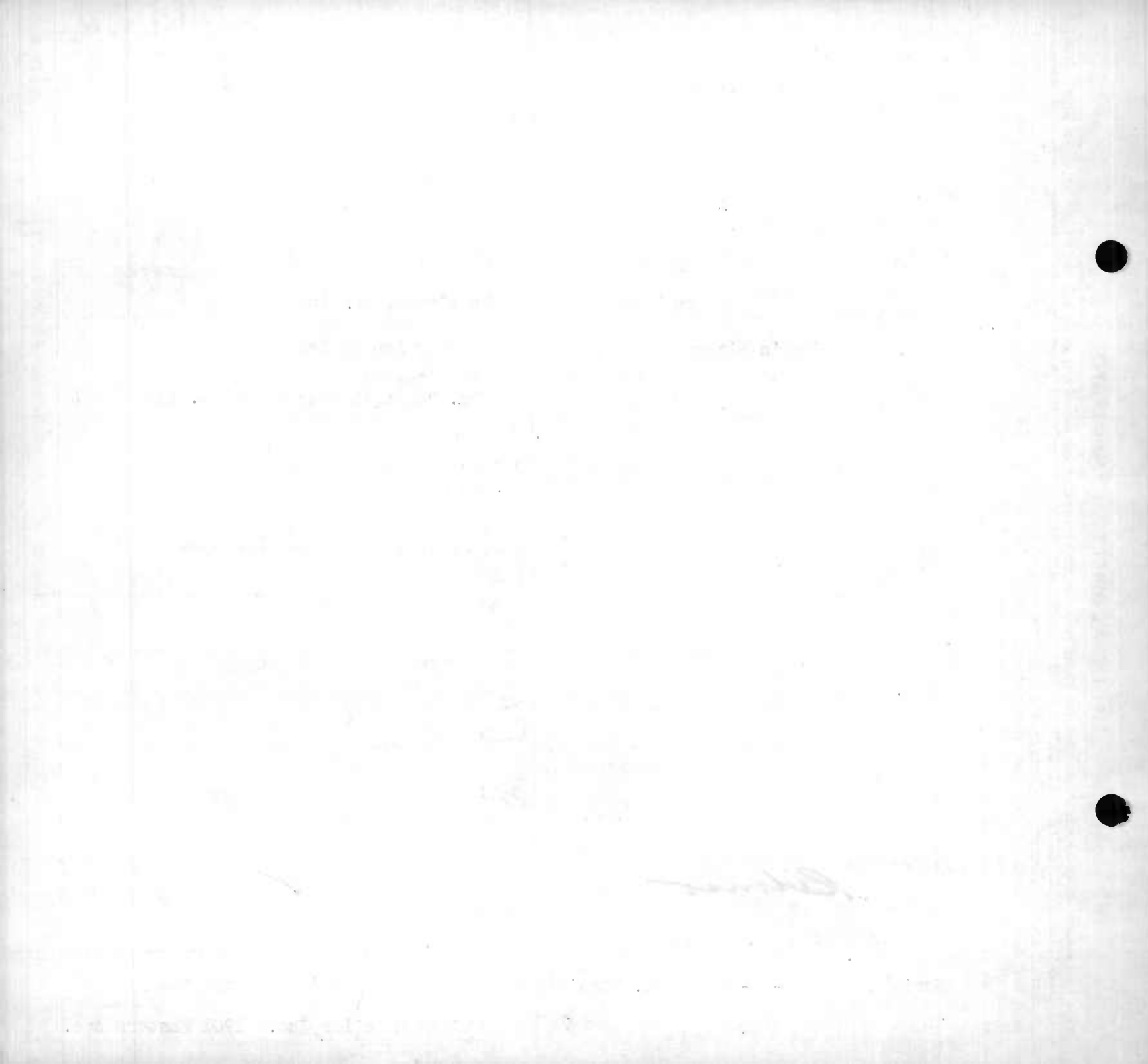
| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | BIRTH NO. 65 3740   |  | CERTIFICATE OF DEATH   |  | Registered No. 65 3740   |  |
|---|--|--|--|---|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>CHARLES EDWARD McCauley</b>   |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>April 6, 1965 10:00 a.m.</b>  |  |  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>1208 W. 40th Street</b>   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>13-08</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1208 W. 40th Street</b> |  |  |  |  |  |
| 5. SEX<br><b>Male</b>   |  | 6. RACE<br><b>White</b>                              |  | 7. MARRIED, NEVER MARRIED<br><b>WIDOWED</b>   |  | 8. DATE OF BIRTH<br><b>Oct. 28, 1867</b>   |  | 9. AGE (In years lost birthday)<br><b>97</b>                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Building</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |  |
| 13. FATHER'S NAME<br><b>Robert V. McCauley</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Jane Haupt</b>  |  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>-</b>   |  | 17. INFORMANT<br><b>Charles P. McCauley, 1115 Weldon Ave. Balto. Md.</b>   |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>420.1 I</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis</b>  |  |  |  | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b>                    |  |
| 19. DATE OF OPERATION<br><b>0</b>   |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 1964</b> to <b>April 6, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 6, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death. |  |  |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Reuben Hoffman</b>   |  |  |  |   |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><b>4-7-65</b>                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Reuben Hoffman</b>   |  |  |  |   |  | 23D. ADDRESS<br>M.D. <b>846 W. 36th Street, Baltimore, Maryland</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>9 Apr 65</b>                         |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Druid Ridge Cemetery</b>   |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Balto. Co., Maryland</b> |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |  |  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Staley</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Burghe Funeral Home, 3631 Falls Rd. Balto. Md.</b>   |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | BIRTH NO. 65 3741  |  | CERTIFICATE OF DEATH  |  | Registered No. 65 3741                    |  |
|--|--|--|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Jawarz, Sophia</b>   |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>April 5 1965 4:45P M.</b>  |  |   |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>41 St. Joseph Hospital</b>   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>26-01</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore #6</b><br>D. STREET ADDRESS (If rural, give location) <b>5001 Hamilton Ave.</b> |  |   |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. RACE<br><b>white</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>widowed</b>   |  | 8. DATE OF BIRTH<br><b>July 7, 1884</b>                                     |  | 9. AGE (In years last birthday) <b>80</b> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>     |  | 12. CITIZEN OF WHAT COUNTRY?              |  |
| 13. FATHER'S NAME<br><b>Martin Piskor</b>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Ann Bogdan</b>   |  |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Margaret Breyer 208 S. Ann Street</b>      |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Cerebro-vascular Hemorrhage left side</b><br>(B) <b>Hypertensive Cardio-vascular disease with Atrial Fibrillation</b><br>(C) _____ |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |   |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>no</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 4 19 65</b> to <b>April 5 19 65</b> , that (I) (we) last saw the deceased alive on <b>April 5 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                              |  |  |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Blonso</b>  |  |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input checked="" type="checkbox"/>   |  |   |  | 23B. DATE SIGNED<br><b>April 5 1965</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Bernardino A. Alonso</b>  |  |  |  | 23D. ADDRESS<br><b>1400 N. Caroline St. Baltimore 21213 Md.</b>  |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>4-10-1965</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>St. Stanislaus</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |  | 25B. NAME OF REGISTRAR<br><b>R. E. E. E. E.</b>  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Dilly &amp; Zeller Inc. 1901 Eastern Ave.</b>  |  |   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  |  |  |  |  |  |  | Registered No. <b>65 3742</b>                          |  |
|---|--|--|--|--|--|--|--|--|--|--|--|
| BIRTH NO. <b>65 3742</b>  |  | <b>STEPHANIE KATALINICH</b>  |  |  |  |  |  | <b>CERTIFICATE OF DEATH</b>  |  |  |  |
| M.E. CASE NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Katalinich, Stephanie</b>                                    |  |  |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>April 7, 1965 1:40 A.M.</b>  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |  |  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>35 Church Home Hospital</b>  |  | (If not in hospital or institution, give street address or location)                                   |  | A. STATE <b>BALTIMORE</b> B. COUNTY <b>MARYLAND</b>                                      |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>27-34</b>   |  |  |  |
| 5. SEX <b>F</b>   |  | 6. RACE <b>W</b>   |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>UNMARRIED</b>             |  | 8. DATE OF BIRTH<br><b>5/29/76</b>                                       |  | 9. AGE (In years last birthday) <b>88</b>  |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>                                     |  | 11. BIRTHPLACE (State or foreign country)<br><b>Belgium</b>              |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>        |  |
| 13. FATHER'S NAME   |  |  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Derricks</b>                              |  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |  |  |  | 16. SOCIAL SECURITY NO.<br><b>-</b>  |  | 17. INFORMANT ADDRESS<br><b>Theodore Katalinich 1628 Aliceanna St.</b>   |  |  |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>422.11 Pulmonary Edema</b>   |  |  |  |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>   |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>ASCVD</b>  |  |  |  |  |  |  |  | years  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Hemiplegia</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |  |  |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>April 6 1965</b> to <b>April 7 1965</b> , that (1) (we) last saw the deceased alive on <b>April 7</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |  |  |  |  |  |  |  |  |  |  |
| 23A. SIGNATURE<br><b>J. Howard Lutz</b>   |  |  |  |  |  |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><b>4/7/65</b>                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>J. HOWARD LUTZ</b>   |  |  |  | 23D. ADDRESS<br>M.D. <b>Church Home Hosp.</b>  |  |  |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>4-10-1965</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Holy Redeemer</b>                               |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |  |  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |  |  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</b>  |  |  |  |

Church Home Hosp

Admitted

M

F

Belgium

2/20/24

18

no

Primary Eczema

ASCD

Graves

Hemiplegia

no

J. Howard Rols  
J. Howard Rols

Church Home Hosp

April 10

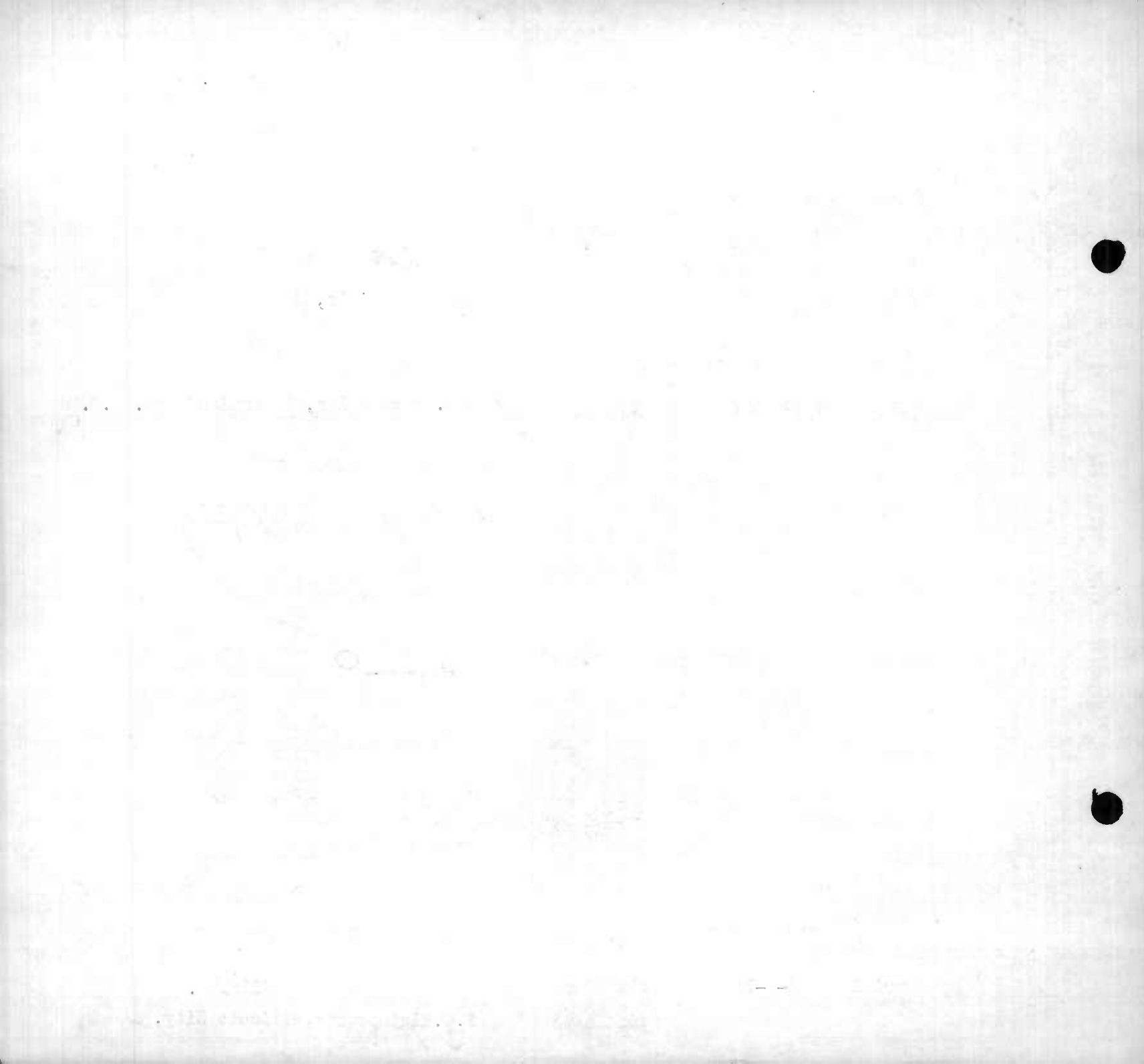
22

April

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department   |           |  |                          | Certificate of Death   |                            | Registered No. 65 3743   |                             |
|--|-----------|--|--------------------------|--|----------------------------|--|-----------------------------|
| BIRTH NO. 65 3743  |           | M.E. CASE NO.  |                          | 1. NAME OF DECEASED (Type or Print) Wiles, Wilbur A  |                            | 2. DATE AND HOUR OF DEATH 10 40 4-6-65 P.M.                          |                             |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |           |  |                          | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)  |                            |  |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION   |           | (If not in hospital or institution, give street address or location)                                   |                          | A. STATE MD  |                            | B. COUNTY Howard   |                             |
| 4 Bon Secours Hospital   |           |  |                          | C. CITY OR TOWN (If outside city limits, write RURAL and give township) ELICOTT CITY - BALTIMORE 63-00                               |                            |  |                             |
| D. STREET ADDRESS (If rural, give location)  |           |  |                          | 45 MARYLAND AVE.   |                            |  |                             |
| 5. SEX MALE  | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED   | 8. DATE OF BIRTH 3/39/20 | 9. AGE (In years lost birthday) 45   | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER  |           | 10B. KIND OF BUSINESS OR INDUSTRY  |                          | 11. BIRTHPLACE (State or foreign country) XXXXXX Daniels, Md.  |                            | 12. CITIZEN OF WHAT COUNTRY? USA                                     |                             |
| 13. FATHER'S NAME Wiles, Wilbur  |           |  |                          | 14. MOTHER'S MAIDEN NAME ESTHER GREEN  |                            |  |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW II   |           | 16. SOCIAL SECURITY NO. 212-01-9439  |                          | 17. INFORMANT ADDRESS Mrs. Grace Wiles, 45 Maryland Ave. E.C. Md   |                            |  |                             |
| 18. 603X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |           |  |                          | (A) DUE TO uremia due to   |                            | INTERVAL BETWEEN ONSET AND DEATH                                     |                             |
| ANTECEDENT CAUSES  |           |  |                          | (B) DUE TO kidney insufficiency  |                            |  |                             |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |           |  |                          | (C)  |                            |  |                             |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |           |  |                          |  |                            |  |                             |
| 19A. DATE OF OPERATION   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          | 20A. AUTOPSY? (Yes or No) Refused  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |  |                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                          | 21F. HOW DID INJURY OCCUR?   |                            |  |                             |
| 22. I certify that (I) (this hospital) attended the deceased from 3/31, 19 65 to 4/6, 19 65, that (I) (we) last saw the deceased alive on 10 40 PM April 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |  |                          |  |                            |  |                             |
| 23A. SIGNATURE DR M. T. AMJAD  |           |  |                          | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                            | 23B. DATE SIGNED 4/6/65  |                             |
| 23C. PHYSICIAN'S NAME (Type) DR. M. T. AMJAD   |           | 23D. ADDRESS M.D. BON-SECOURS HOSPITAL   |                          |  |                            |  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |           | 24B. DATE 4-9-1965   |                          | 24C. NAME of CEMETERY or CREMATORY Lake View   |                            | 24D. LOCATION (City, town, or county) (State) Oakland Mills, Md.     |                             |
| 25A. DATE REC'D BY HEALTH DEPT. APR 8 1965   |           | 25B. NAME OF REGISTRAR Robert E. Jackson   |                          | 25C. FUNERAL DIRECTOR F.C. Higinbotham   |                            | ADDRESS Ellisott City, Md  |                             |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

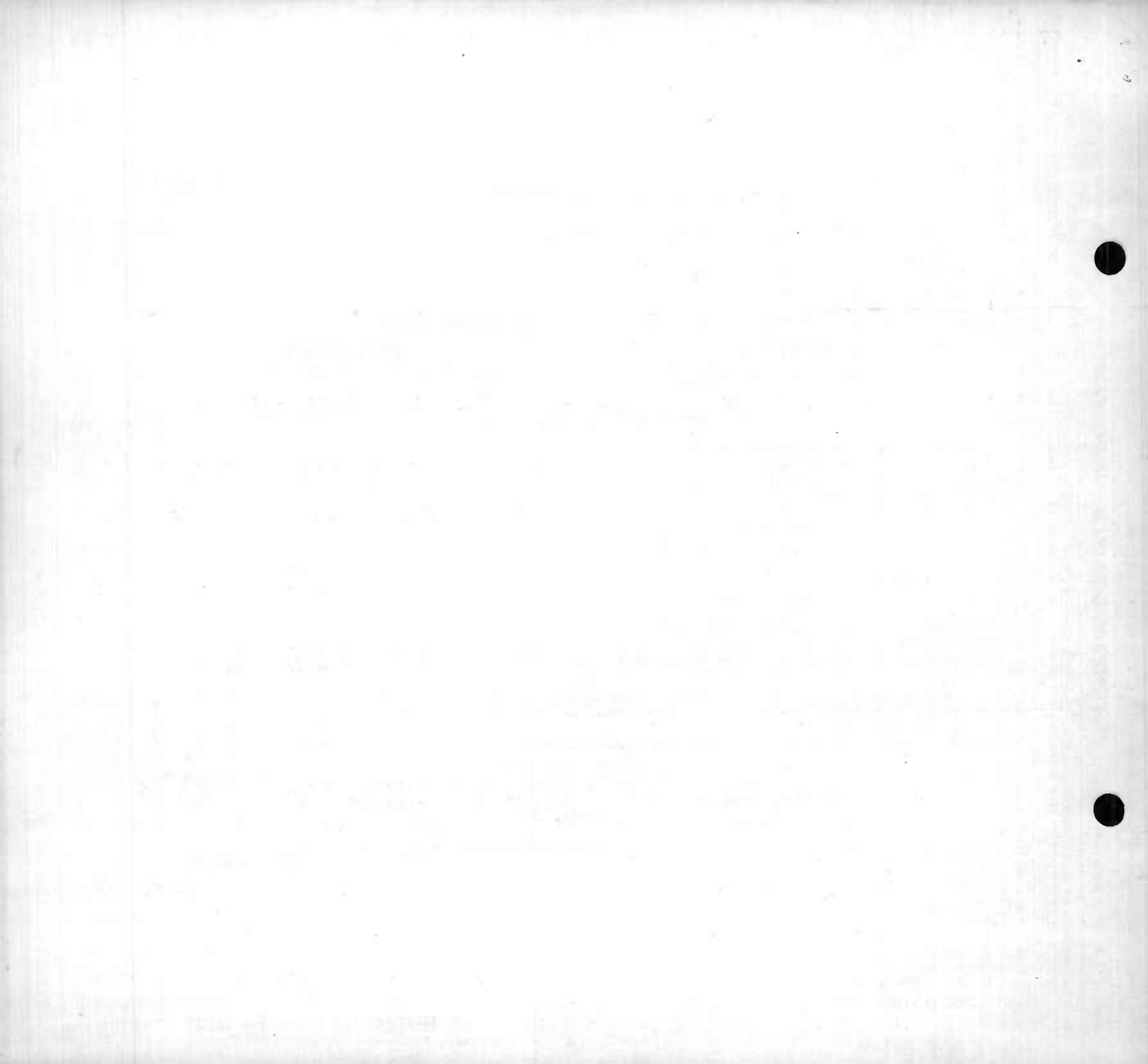
| BALTIMORE CITY HEALTH DEPT.  |                         |   |  | Registered No.   |                                |
|--|-------------------------|---|--|--|--------------------------------|
| BIRTH NO. <b>65 3744</b>   |                         | <b>CERTIFICATE OF DEATH</b>   |  | 65 3744  |                                |
| M.E. CASE NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>IDA SNYDER</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>4-5-65 12:40 P.M.</b>                    |                                |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Gracia Hospital</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>27-18</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>3612 W. Garrison Ave</b> |  |  |                                |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, <del>DIVORCED</del> (Specify)<br><b>NEVER MARRIED</b>   |  | 8. DATE OF BIRTH   | 9. AGE (In years)<br><b>74</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>TAILORING</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>LADIES CLOTHES</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>RUSSIA</b>               |                                |
| 13. FATHER'S NAME<br><b>UNKNOWN</b>  |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |  |                                |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>MRS. BESSIE GLASSMAN</b>                             |                                |
|  |                         |   |  | ADDRESS<br><b>3612 W GARRISON AVE</b>                                    |                                |
| 18. <b>420.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocardial Infarction</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>HASCUD</b> |                         | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |                                |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Increasing Arteriosclerosis</b>   |                         |   |  |  |                                |
| 19A. DATE OF OPERATION<br><b>2</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>yes</b>                                  |                                |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |                                |
| 22. I certify that (I) <b>(this hospital)</b> attended the deceased from <b>3-25</b> 19 <b>65</b> to <b>4-5</b> 19 <b>65</b> , that (I) <b>(we)</b> last saw the deceased alive on <b>4-5</b> 19 <b>65</b> and that in my <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>(We)</b> <b>(did)</b> (did not) view the body after death.                       |                         |   |  |  |                                |
| 23A. SIGNATURE<br><b>G. Martori</b>  |                         |   |  | 23B. DATE SIGNED<br><b>4-5-65</b>  |                                |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Gregorio Martori</b>  |                         |   |  | 23D. ADDRESS<br><b>efo Gracia Hospital</b>                               |                                |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>4/6/65</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>WORKMENS CIRCLE</b>             |                                |
| 24D. LOCATION<br><b>BALTIMORE MARYLAND</b>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |  |  |                                |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |                         | 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS. INC.</b>   |  |  |                                |
|  |                         | ADDRESS<br><b>6010 REISTERSTOWN RD</b>  |  |  |                                |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |  |  | Registered No. <u>65 3745</u>   |   |
|--|-------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <span>BIRTH NO. <u>65 3745</u></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>   |                         |  |  |   |   |
| <div style="display: flex; justify-content: space-between;"> <div> M.E. CASE NO.<br/> 1. NAME OF DECEASED<br/> (Type or Print) <u>WILLIAM HYMAN ZEMEL</u> </div> <div> 2. DATE AND HOUR OF DEATH<br/> <u>4/6/65</u> <u>4:40 P. M.</u> </div> </div>  |                         |  |  |   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>SINAI HOSPITAL</u>   |                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <u>MD.</u> B. COUNTY <u>27-18</u><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>5414 Nelson Ave. #15</u><br>D. STREET ADDRESS (If rural, give location) |   |   |
| 5. SEX<br><u>MALE</u>  | 6. RACE<br><u>WHITE</u> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><u>MARRIED</u>                             | 8. DATE OF BIRTH<br><u>4/13/21</u>   | 9. AGE (In years<br>last birthday)<br><u>43</u>                           | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>INSURANCE</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>SALESMAN</u>   | 11. BIRTHPLACE (State or foreign country)<br><u>NEW YORK</u>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                |
| 13. FATHER'S NAME<br><u>MAX ZEMEL</u>  |                         |  | 14. MOTHER'S MAIDEN NAME<br><u>DORA RUTHSTEIN</u>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>YES</u> <u>WW 2 ARMY</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>218-26-8625</u>  | 17. INFORMANT ADDRESS<br><u>MRS. MILDRED ZEMEL 5414 NELSON AVE</u>   |   |   |
| 18. <u>200.0 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>RETICULUM CELL SARCOMA (3 MOS)</u><br><u>AGGRAVATED BY MYOCARDIAL INFARCTION.</u>   |                         |  | CAUSE OF DEATH<br>INTERVAL BETWEEN ONSET AND DEATH   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |  |   |   |
| 19A. DATE OF OPERATION<br><u>0</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <u>NO</u>                                       |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4/6/65 (4:47 P.M.)</u> to <u>4/6/65</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4/6/65</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |  |   |   |
| 23A. SIGNATURE<br><u>Gerardo M. Ypil Jr.</u> M.D.  |                         |  |  | 23B. DATE SIGNED<br><u>4/6/65</u>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>GERARDO M. YPIL JR.</u> M.D.  |                         |  |  | 23D. ADDRESS<br><u>SINAI HOSPITAL</u>                                     |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                         | 24B. DATE<br><u>4/7/65</u>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>SWINICKER BENEVOLENT SOCIETY</u> |   |
| 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE MARYLAND</u>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 8 1965</u>   |  |   |   |
| 25B. NAME OF REGISTRAR<br><u>Robert E. Schuyler</u>  |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>             |  |   |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |                     |  |  |   |                                      |  |  |  |  |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
|--|--|---------------------|--|--|---|--------------------------------------|--|--|--|--|--|-----------------------------|--|--|---|--|--|--|--|--|--|--|--|--|
| BIRTH NO. 65 3746  |  |                     |  |  | CERTIFICATE OF DEATH  |                                      |  |  |  | Registered No. 65 3746   |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>EMMA MARIE WOLFORD</b>   |  |                     |  |  | 2. DATE AND HOUR OF DEATH<br><b>4/4/65 10.50 a.m.</b>   |                                      |  |  |  |  |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Church Home &amp; Hospital</b>   |  |                     |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Allegany</b><br>C. CITY OR TOWNSHIP (If outside city limits, write RURAL and give township)<br><b>Corrigansville, 57-00</b><br>D. STREET ADDRESS (If rural, give location)<br><b>Route I Box 1678 Mt. Savage Rd.</b> |                                      |  |  |  |  |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 5. SEX<br><b>F</b>   |  | 6. RACE<br><b>W</b> |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>married</b> |   | 8. DATE OF BIRTH<br><b>3/15/1903</b> |  | 9. AGE (In years lost birthday)<br><b>62</b> |  | If Under 1 Yr. Months Days   |  | If Under 24 Hrs. Hours Min. |  |  |   |  |  |  |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>  |  |                     |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own home</b>  |                                      |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Garrett, Penna.</b>  |  |                             |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                      |  |  |  |  |  |  |  |  |  |
| 13. FATHER'S NAME<br><b>Harry Porter</b>   |  |                     |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Kendall</b>   |                                      |  |  |  |  |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No,</b>   |  |                     |  |  | 16. SOCIAL SECURITY NO.<br><b>None</b>  |                                      |  |  |  | 17. INFORMANT<br><b>Mr. Francis Troutman 2103 Hollands Ferry Rd.</b>   |  |                             |  |  | ADDRESS <b>Balto. Md.</b>   |  |  |  |  |  |  |  |  |  |
| 18. <b>260X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>Cerebrovascular accident</b><br>DUE TO<br>(B) <b>Diabetes mellitus</b><br>DUE TO<br>(C) <b>Hypertension</b><br><b>Congestive heart failure</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>5 days</b> |  |                     |  |  |   |                                      |  |  |  |  |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 19. DATE OF OPERATION<br><b>0</b>  |  |                     |  |  |   |                                      |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                             |  |  | 20A. AUTOPSY? (Yes or No)   |  |  |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |  |                     |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                      |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |                     |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                      |  |  |  | 21F. HOW DID INJURY OCCUR?   |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/30/65</b> 19 to <b>4/4/65</b> 19, that (I) (we) last saw the deceased alive on <b>4/4/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |                     |  |  |   |                                      |  |  |  |  |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Antoine Arrage</b>  |  |                     |  |  |   |                                      |  |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |                             |  |  | 23B. DATE SIGNED<br><b>4/4/65</b>   |  |  |  |  |  |  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Antoine Arrage</b>  |  |                     |  |  |   |                                      |  |  |  | M.D. 23D. ADDRESS<br><b>Church Home &amp; Hospital</b>   |  |                             |  |  |   |  |  |  |  |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                     |  |  | 24B. DATE<br><b>4/7/65</b>  |                                      |  |  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Temple Cemetery,</b>  |  |                             |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Nr. Wellersburg, Penna.</b> |  |  |  |  |  |  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |  |                     |  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b>   |                                      |  |  |  | 25C. FUNERAL DIRECTOR<br><b>Wayne George</b>   |  |                             |  |  | ADDRESS <b>202 Greene St. Cumberland, Md.</b>                                   |  |  |  |  |  |  |  |  |  |

1872-73

1872-73

Received of the  
Hon. Secy of the  
Treasury for the  
year ending 1872

Arthur Tappan

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |   |   |  |  | Registered No.   |  |
|---|------------------|---|---|--|--|--|--|
| BIRTH NO. 65 3747   |                  | CERTIFICATE OF DEATH  |   |  |  | 65 3747  |  |
| M.E. CASE NO. 1. NAME OF DECEASED<br>(Type or Print) MARGARET F. DENNY  |                  |   |   | 2. DATE AND HOUR OF DEATH<br>4-6-65 12:35 P.M.   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>LUTHERAN HOSP. OF Md.  |                  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY 28-02<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE<br>D. STREET ADDRESS (If rural, give location)<br>4409 WENTWORTH RD |  |  |  |
| 5. SEX<br>Female  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>WIDOWED                                       | 8. DATE OF BIRTH<br>8-4-84  | 9. AGE (In years last birthday)<br>80  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br>BALTO.  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                  |  |
| 13. FATHER'S NAME<br>JAMES SULLIVAN   |                  |   | 14. MOTHER'S MAIDEN NAME<br>MARGARET KENNEDY  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                  |   | 16. SOCIAL SECURITY NO.<br>- 213-12-8090A   |  | 17. INFORMANT<br>JAMES PATRICK DENNY                   |  |  |
| 18. 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   | CAUSE OF DEATH<br>LAUREL, Md<br>(A) CEREBRAL HEMORRHAGE<br>DUE TO<br>(B) GEN. ARTERIOSCLEROSIS<br>DUE TO<br>(C) |  |  | INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |   |   |  |  |  |  |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br>No  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4-4-65 to 4-6-65, 1965, that (I) (we) last saw the deceased alive on 4-6-65, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                     |                  |   |   |  |  |  |  |
| 23A. SIGNATURE<br>Renato R. Espina M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |                  |   |   |  |  | 23B. DATE SIGNED   |  |
| 23C. PHYSICIAN'S NAME (Type) RENATO R. ESPINA   |                  |   |   | 23D. ADDRESS<br>LUTHERAN HOSP. OF MD   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4-9-65   |   | 24C. NAME of CEMETERY or CREMATORY<br>New Cathedral Cem.   |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |   | 25C. FUNERAL DIRECTOR<br>J. E. L. Worth, Jr. Address: 4600 Liberty Heights   |  |  |  |

HOUSE WIFE  
F W  
MID  
8-1-24  
2

CHART

GEN. ARTHUR M. CROCKETT  
CENTRAL HOSPITAL

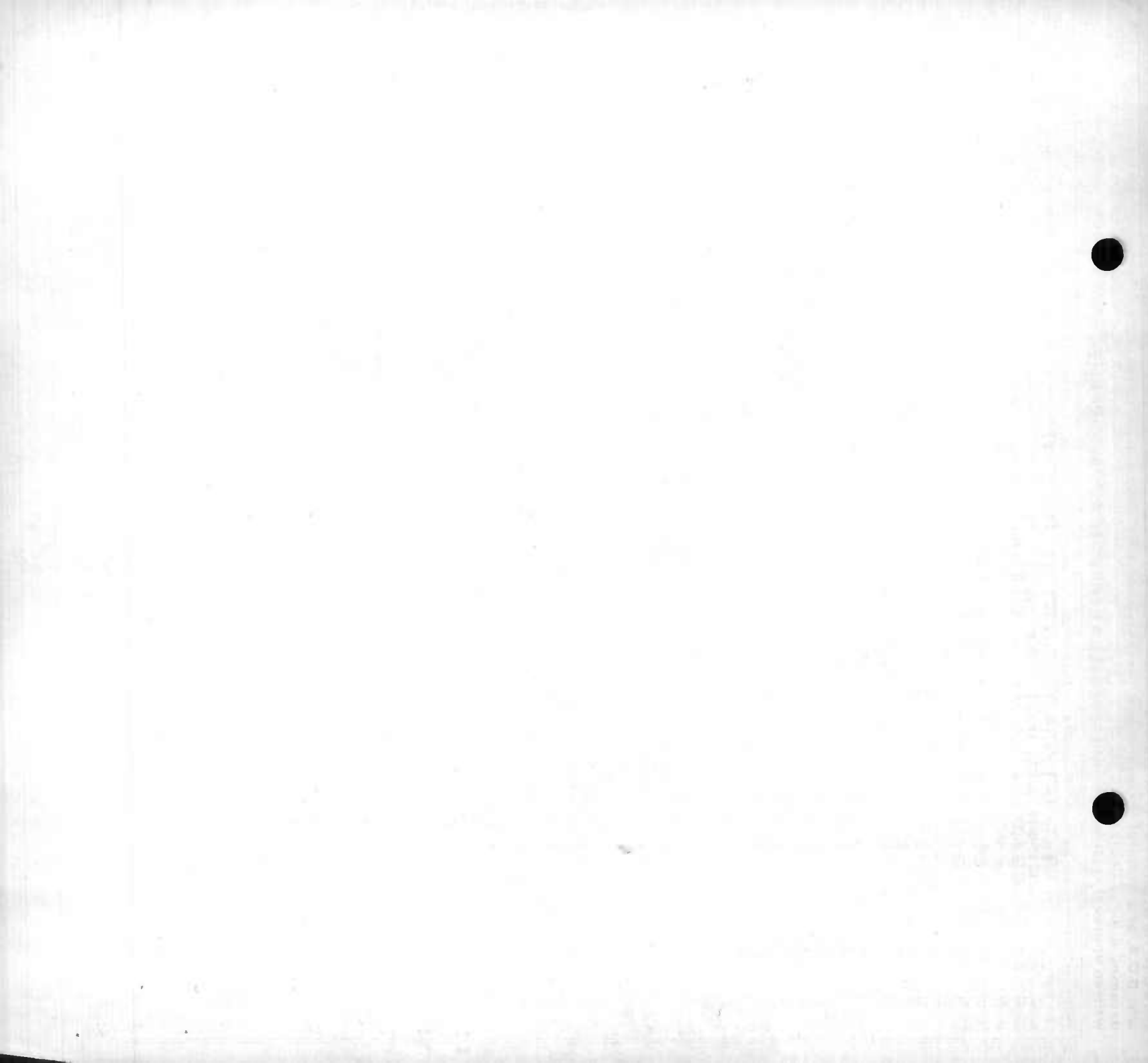
CHART  
F W  
MID  
8-1-24  
2



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | Registered No. <span style="float: right;">65 3748</span>  |   |
|--|--|---|--|--|---|
| BIRTH NO. <span style="font-size: 1.5em;">65 3748</span>   |  | <b>CERTIFICATE OF DEATH</b>   |  |  |   |
| M.E. CASE NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">PARROTT, George H.</span>  |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">DOA April 7 1965 12<sup>20</sup> A.M.</span>            |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.2em;">DOA at South Baltimore General Hospital</span>   |  | A. STATE <span style="font-size: 1.2em;">Md</span> B. COUNTY <span style="font-size: 1.2em;">#30 2404</span>                                |  |  |   |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.2em;">Baltimore</span>  |  | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.2em;">1519 Henry St Balto #30</span>                               |  |  |   |
| 5. SEX <span style="font-size: 1.2em;">M</span>  | 6. RACE <span style="font-size: 1.2em;">W</span> | 7. <input checked="" type="checkbox"/> MARRIED NEVER MARRIED WIDOWED, DIVORCED (specify)  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">May 15 1899</span> | 9. AGE (In years last birthday) <span style="font-size: 1.2em;">65</span>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Confectioner</span>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">Confectioner</span>  |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">VA</span>                               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U. S. A</span>   |  | 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Charles</span>   |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Sadie BRUCE</span>                                       |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><span style="font-size: 1.2em;">Wife</span> ADDRESS <span style="font-size: 1.2em;">As above</span> |   |
| 18. <span style="font-size: 1.2em;">420.11</span>  |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  | (A) <span style="font-size: 1.2em;">myocardial infarction</span>  |  | <span style="font-size: 1.2em;">STAT.</span>   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) <span style="font-size: 1.2em;">Atrial Fibrillation</span>  |  | <span style="font-size: 1.2em;">4 1/2 months</span>  |   |
|  |  | (C) <span style="font-size: 1.2em;">Old Anteroseptal Myoc. Infarct</span>   |  | <span style="font-size: 1.2em;">4 1/2 months</span>  |   |
| II   |  |   |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><span style="font-size: 1.2em;">Congestive Cardiac Failure</span>  |  |   |  |  |   |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">0</span>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">No</span>   |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>                              |  |  |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                      |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <span style="font-size: 1.2em;">11/27/1964</span> to <span style="font-size: 1.2em;">4/7/1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">about March 18, 1965</span> and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death. |  |   |  |  |   |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Sherwood Wilson</span> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  |   |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">4/7/65</span>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">SHERWOOD WILSON</span> M.D.  |  |   |  | 23D. ADDRESS<br><span style="font-size: 1.2em;">South Baltimore General Hospital</span>                              |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>  |  | 24B. DATE<br><span style="font-size: 1.2em;">4 10 65</span>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Prize Hill</span>                              |   |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Charlottesville, Va.</span>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">APR 8 1965</span>  |  |  |   |
| 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Taylor M.D.</span>   |  | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">J. E. Gilly</span> ADDRESS <span style="font-size: 1.2em;">130 E. Fort Ave.</span> |  |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

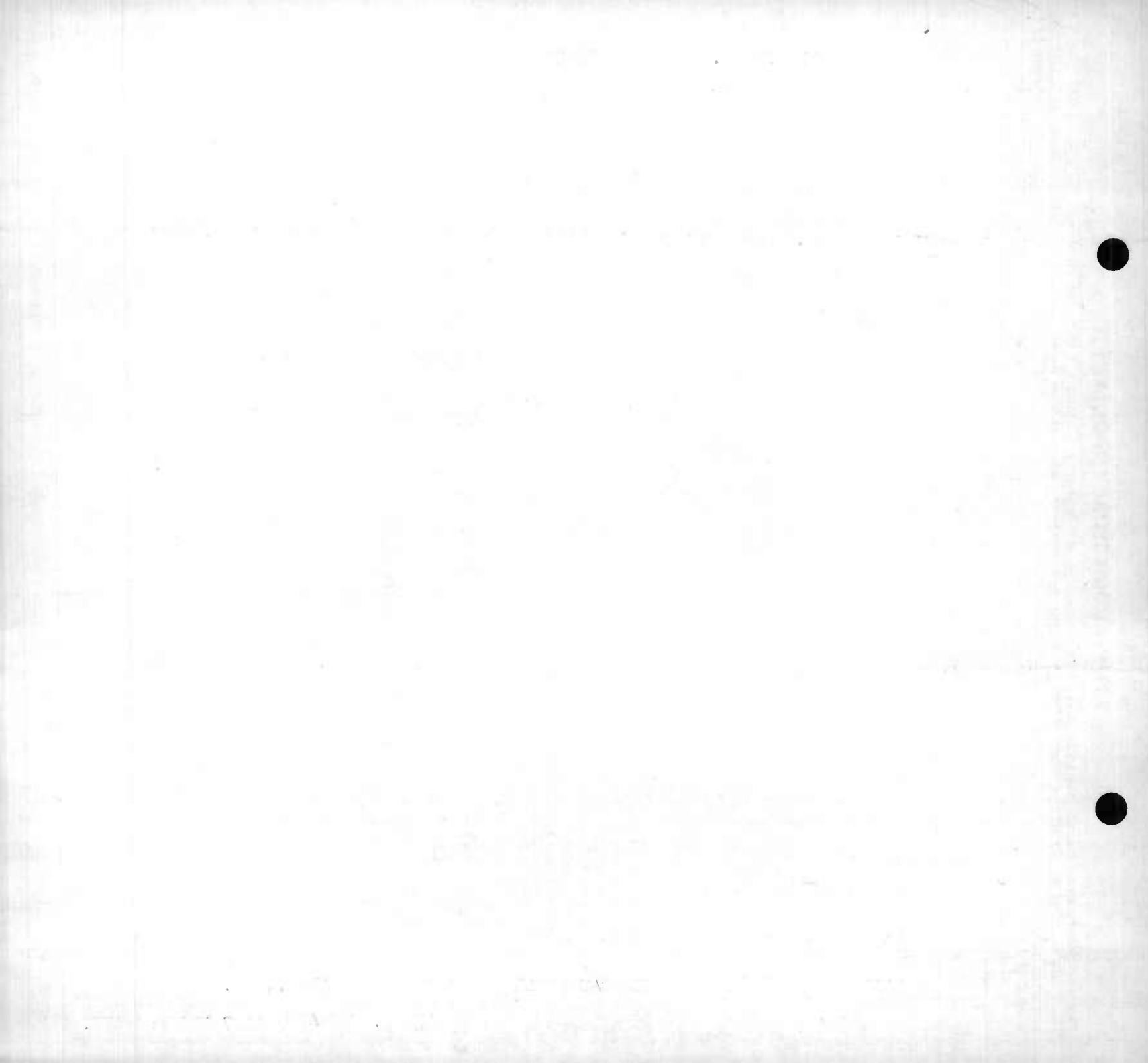
|   |                  |   |                             |  |   |
|---|------------------|---|-----------------------------|--|---|
| BIRTH NO. 65 3749   |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                             | Registered No. 65 3749   |   |
| M.E. CASE NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) <del>XXXXXXXXXXXX</del> JAMES WALLACE FRAME  |                             | 2. DATE AND HOUR OF DEATH<br>4/4/65 4:30 A.M.                            |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>University Hospital  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY 25-41<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore 21229<br>D. STREET ADDRESS (If rural, give location)<br>3711 Wilkens Ave |                             |  |   |
| 5. SEX<br>Male  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br>married   | 8. DATE OF BIRTH<br>8/20/85 | 9. AGE (In years lost birthday)<br>79                                    | If Under 1 Yr. Months: Ooys: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired-Maintenance  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>GUARD Race Track   |                             | 11. BIRTHPLACE (State or foreign country)<br>Va.                         | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                    |
| 13. FATHER'S NAME<br>Thomas Frame   |                  | 14. MOTHER'S MAIDEN NAME<br>Mollie  |                             |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                  | 16. SOCIAL SECURITY NO.<br>212-12-5677  |                             | 17. INFORMANT<br>Mrs. Nellie K. Frame-3711 Wilkens Ave-21229             |   |
| 18. 204.01<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                  | CAUSE OF DEATH<br>(A) Pneumococcal pneumonia<br>DUE TO<br>(B) Chronic Lymphocytic leukemia<br>DUE TO<br>(C)   |                             | INTERVAL BETWEEN ONSET AND DEATH<br>70 hours                             |   |
| 19A. DATE OF OPERATION<br>2   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             | 20A. AUTOPSY? (Yes or No)<br>Yes   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                             | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 4/2 19 65 to 4/4 19 65, that (I) (we) last saw the deceased alive on 4/4 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                             |  |   |
| 23A. SIGNATURE<br>Jonathan Tuerk  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                             | 23B. DATE SIGNED<br>4/4/65   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Jonathan Tuerk  |                  | 23D. ADDRESS<br>M.O. University Hospital  |                             |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4-7-65   |                             | 24C. NAME of CEMETERY or CREMATORY<br>Meadowridge Memorial Park          |   |
|   |                  |   |                             | 24D. LOCATION (City, town, or county) (State)<br>Elkridge, Maryland      |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                             | 25C. FUNERAL DIRECTOR<br>Howard H. Hubbard-4107 Wilkens Ave-21229        |   |
|   |                  |   |                             | ADDRESS  |   |

1994

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

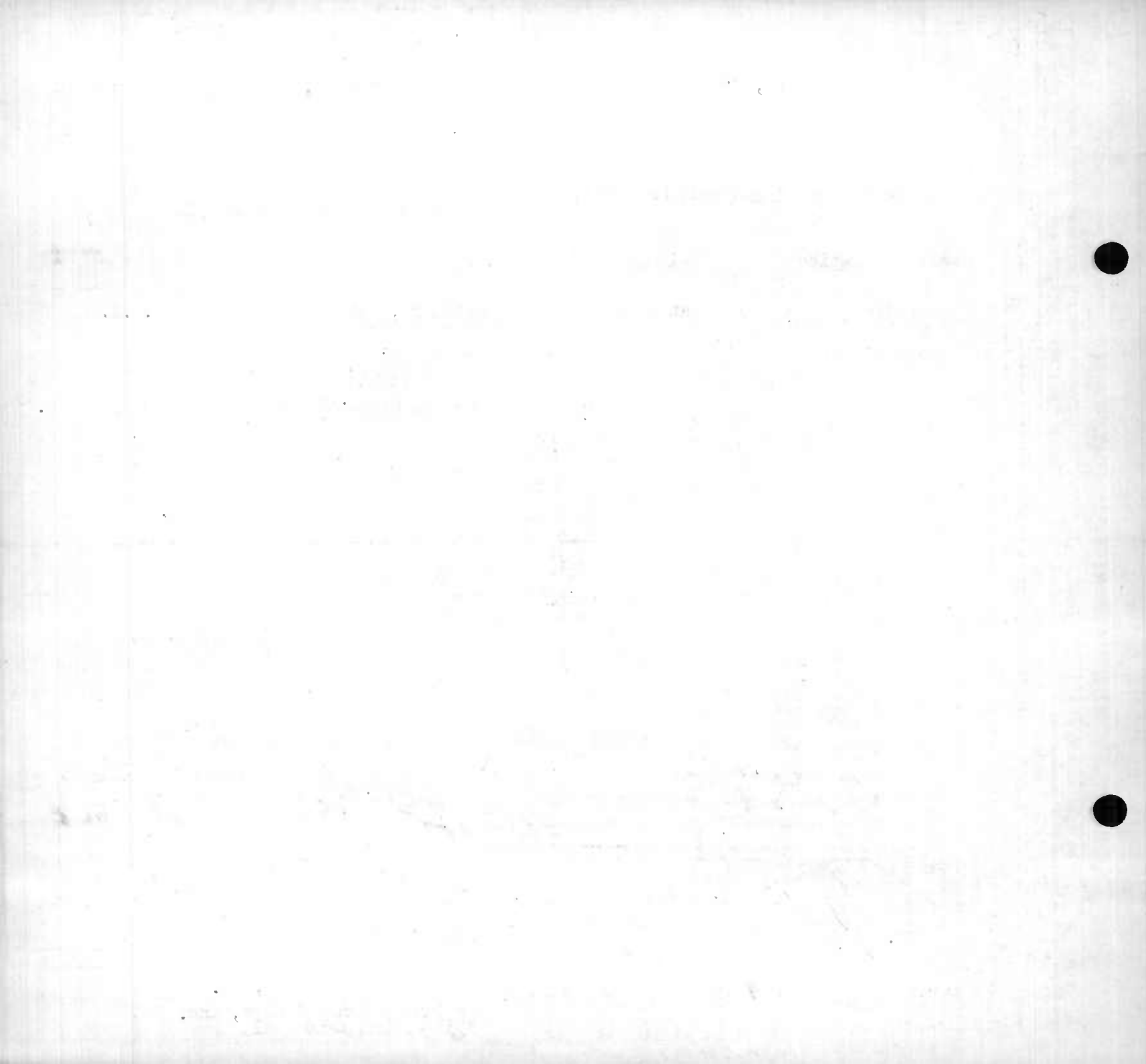
|   |           |  |   |  |                                   |
|---|-----------|--|---|--|-----------------------------------|
| BIRTH NO. 65 3750   |           | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3750   |                                   |
| M.E. CASE NO.   |           | 1. NAME OF DECEASED MINNIE R. WIESINGER  |   | 2. DATE AND HOUR OF DEATH APRIL 5, 1965 3:30 AM.                         |                                   |
| (Type or Print) MINNIE R. WIESINGER   |           |  |   |  |                                   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |   |  |                                   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |           | A. STATE MD. B. COUNTY 27-Q3   |   |  |                                   |
| MONTEBELLO STATE HOSPITAL   |           | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO.                         |   |  |                                   |
|   |           | D. STREET ADDRESS (If rural, give location) 5207 HARFORD RD.   |   |  |                                   |
| 5. SEX F  | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE  | 8. DATE OF BIRTH MAR. 14, 1903                | 9. AGE (In years last birthday) 62                                       | 10. Under 1 Yr. Months Days       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE   |           | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country) MD. |  | 12. CITIZEN OF WHAT COUNTRY? U.S. |
| 13. FATHER'S NAME FRANK WIESINGER   |           | 14. MOTHER'S MAIDEN NAME MINNIE RULEHL   |   | 17. INFORMANT ADDRESS  |                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |           | 16. SOCIAL SECURITY NO. 212-20-6197  |   | CHART of PATIENT.  |                                   |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |           | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |                                   |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  |           | (A) CARCINOMA OF OVARY DUE TO  |   | 3 MOS  |                                   |
| ANTECEDENT CAUSES   |           | (B) DUE TO   |   |  |                                   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |           | (C)  |   |  |                                   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |           |  |   |  |                                   |
| 19A. DATE OF OPERATION 2  |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) YES  |                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |                                   |
| 22. I certify that (1) (this hospital) attended the deceased from 3-23 1965 to 4-5 1965, that (1) (we) last saw the deceased alive on 4-5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |           |  |   |  |                                   |
| 23A. SIGNATURE Irving L. Cooperstein  |           |  |   | 23B. DATE SIGNED APR. 5, 1965  |                                   |
| 23C. PHYSICIAN'S NAME (Type) IRVING L. COOPERSTEIN M.D.   |           |  |   | 23D. ADDRESS MONTEBELLO STATE HOSP.                                      |                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL   |           | 24B. DATE 4/8/65   |   | 24C. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY                |                                   |
|   |           |  |   | 24D. LOCATION (City, town, or county) BALTO., MD. (State)                |                                   |
| 25A. DATE REC'D BY HEALTH DEPT. APR 8 1965  |           | 25B. NAME OF REGISTRAR Robert E. Taylor  |   | 25C. FUNERAL DIRECTOR ADDRESS HOWARD H. HUBBARD 4107 WILKENS AVE. 21229  |                                   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |               |  |                                 |  |   |
|---|---------------|--|---------------------------------|--|---|
| BIRTH NO. 65 3751   |               | BALTIMORE CITY HEALTH DEPARTMENT   |                                 | Registered No. 65 3751   |   |
| M.E. CASE NO.   |               | CERTIFICATE OF DEATH   |                                 |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)  |               | 2. DATE AND HOUR OF DEATH  |                                 |  |   |
| DRIMAL, OR DRIMOL ANNA MARY   |               | April 6, 1965  |                                 | 6:20 am M.   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                                 |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |               | A. STATE Maryland  |                                 | B. COUNTY 26-44  |   |
| House in the Pines (Belair Road)  |               | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |                                 | Baltimore  |   |
|   |               | D. STREET ADDRESS (If rural, give location)  |                                 | 11 North Highland Avenue #24   |   |
| 5. SEX FEMALE   | 6. RACE white | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed  | 8. DATE OF BIRTH April 24, 1874 | 9. AGE (In years last birthday) 90                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |               | 10B. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country)                                |   |
| Housewife   |               | at home  |                                 | Baltimore, Maryland  |   |
| 13. FATHER'S NAME   |               | 14. MOTHER'S MAIDEN NAME   |                                 | 12. CITIZEN OF WHAT COUNTRY?   |   |
| Joseph Hlavin   |               | Mary Humpal  |                                 | U.S.A.   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |               | 16. SOCIAL SECURITY NO.  |                                 | 17. INFORMANT (dght) ADDRESS   |   |
|   |               | none   |                                 | Marie Di Clementi 3402 East Fairmount Ave. #24                           |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |               | CAUSE OF DEATH   |                                 | INTERVAL BETWEEN ONSET AND DEATH   |   |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |               | Uremia   |                                 | 1 week   |   |
| ANTECEDENT CAUSES   |               | Chronic Pyelonephritis   |                                 | 72y  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |               | Nephrolithiasis  |                                 | 72y  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |               | Fracture left hip (pinned)   |                                 | 6 mos  |   |
| 19A. DATE OF OPERATION  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20A. AUTOPSY? (Yes or No)  |   |
| 0   |               |  |                                 | No   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
|   |               | Nursing home   |                                 | 5800 Belair Rd.  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |               | 21E. INJURY OCCURRED   |                                 | 21F. HOW DID INJURY OCCUR?   |   |
| Nov 25 64 5:30 PM   |               | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>   |                                 | fell to floor going to toilet  |   |
| 22. I certify that (I) (the hospital) attended the deceased from 4/13 19 65 to 4/6 19 65 that (I) (we) last saw the deceased alive on 4/13 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |  |                                 |  |   |
| 23A. SIGNATURE  |               | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                 | 23B. DATE SIGNED   |   |
| Dr. Albert Bradley  |               |  |                                 | 4/6/65   |   |
| 23C. PHYSICIAN'S NAME (Type)  |               | 23D. ADDRESS   |                                 |  |   |
| Dr. Albert Bradley  |               | 4900 Belair Road   |                                 |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |               | 24B. DATE  |                                 | 24C. NAME OF CEMETERY or CREMATORY                                       |   |
| Burial  |               | 4/9/65   |                                 | Oak Lawn Cemetery  |   |
|   |               |  |                                 | Baltimore, Md.   |   |
| 25A. DATE REC'D BY HEALTH DEPT.   |               | 25B. NAME OF REGISTRAR   |                                 | 25C. FUNERAL DIRECTOR  |   |
| APR 8 1965  |               | R. B. E. Taylor  |                                 | Schlimmer Funeral Home, Inc.   |   |
|   |               |  |                                 | 3331 Prehms Lane #13   |   |





F. 360

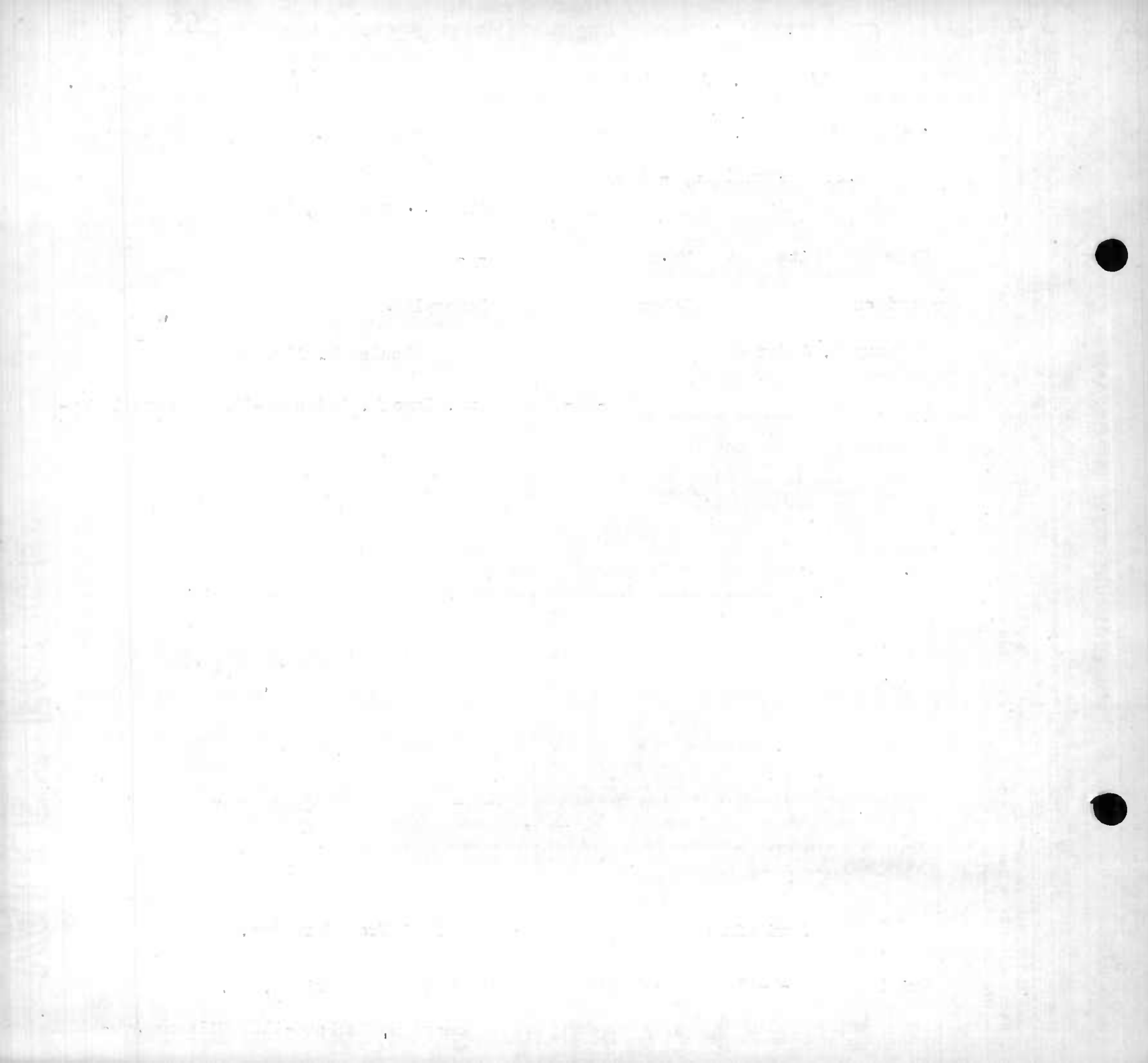
|   |                         |   |   |  |   |
|---|-------------------------|---|---|--|---|
| BIRTH NO. 65 3752   |                         | BALTIMORE CITY HEALTH DEPARTMENT  |   | 65 3752  |   |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. _____  |                         |   |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Ellsworth NORMAN FADER</b>  |                         |   | 2. DATE AND HOUR PRONOUNCED DEAD<br><b>April 6, 1965 2:07 P.M.</b>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST. JOSEPH HOSPITAL</b>   |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location) <b>5919 Benton Heights Ave.</b> |  |   |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>married</b>                                | 8. DATE OF BIRTH<br><b>9/5/22</b>   | 9. AGE (In years last birthday)<br><b>42</b>   | If Under 1 Yr. If Under 24 Hrs.<br>Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Painter-carpenter</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>self-employed</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |   |
| 13. FATHER'S NAME<br><b>Robert Fader</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Florence Vogel</b>   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown). (If yes, give war or dates of service)<br><b>yes W.W.2 - army</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>215-18-6109</b>   |   | 17. INFORMANT ADDRESS<br><b>Marjorie Smith Fader, wife, above</b>  |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Gastro-intestinal hemorrhage due to esophageal varicose</b><br><b>(B) Advanced cirrhosis of the liver with fatty metamorphosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(C)</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                         |   |   |  | INTERVAL BETWEEN ONSET AND DEATH                          |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>  |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>   |                         |   |   |  |   |
| ACTUAL SIGNATURE<br><b>John E. Adams</b>  |                         | EXAMINER'S NAME (Type)<br><b>John E. Adams, M.D.</b>  |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |   |
| 23A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 23B. DATE<br><b>4/9/65</b>  |   | 23C. NAME of CEMETERY or CREMATORY<br><b>Balto. Nat. Cem.</b>  |   |
| 24A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |                         | 24B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |   | 24C. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc</b><br><b>3331 Brehms Lane</b>   |   |
| 23D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |                         | 24D. ADDRESS<br><b>3331 Brehms Lane</b>   |   |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

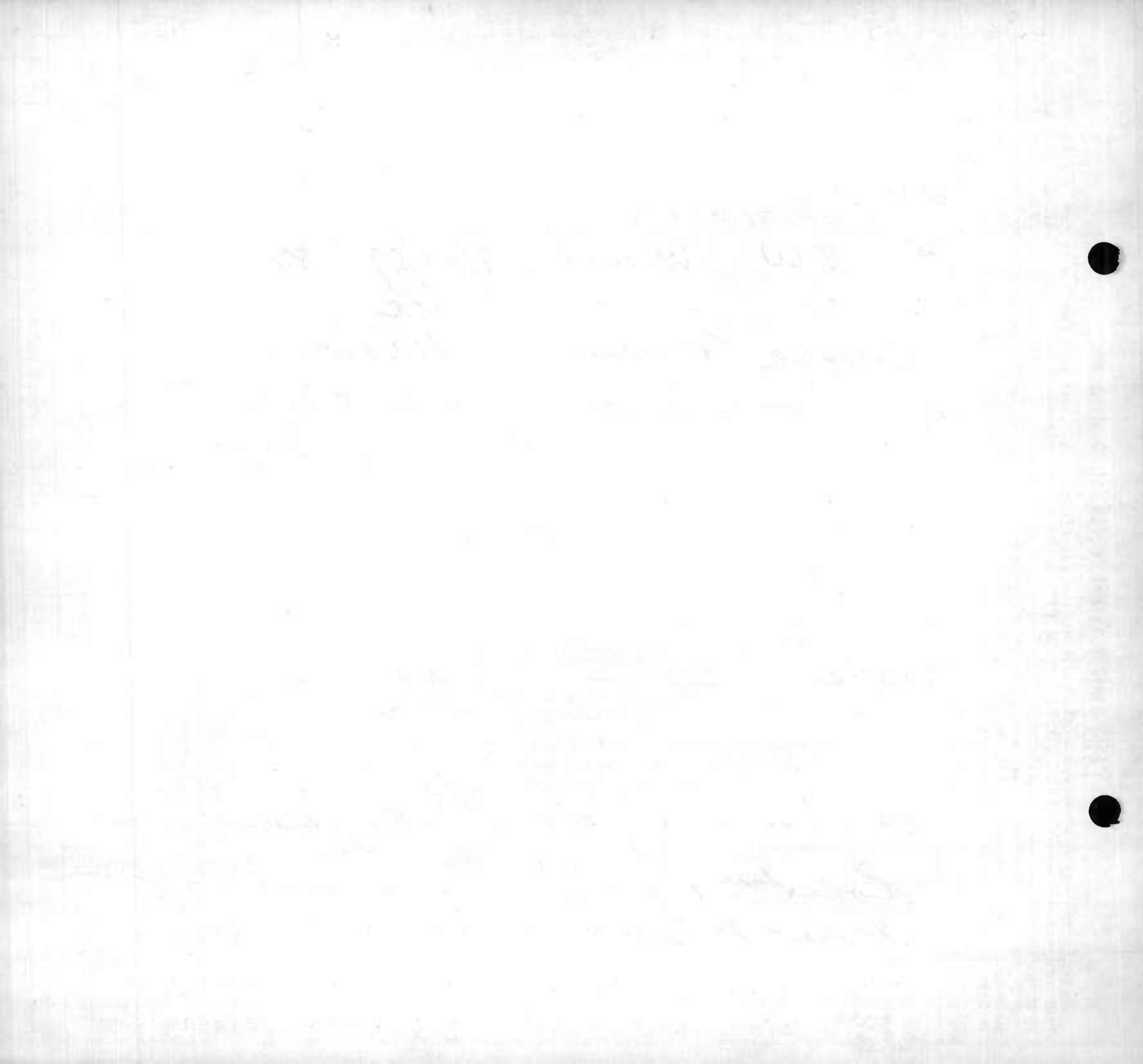
| BIRTH NO. 65 3753   |                  |   |                            | BALTIMORE CITY HEALTH DEPARTMENT   |                               | Registered No. 65 3753   |  |
|---|------------------|---|----------------------------|--|-------------------------------|--|--|
| M.E. CASE NO.   |                  |   |                            | CERTIFICATE OF DEATH   |                               |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) HARRY C. ANDERSON  |                  |   |                            | 2. DATE AND HOUR OF DEATH<br>4/6/65 7:05 a. m.   |                               |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>1155 Quantril Way -21205   |                  |   |                            | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>1155 Quantril Way, 21205 |                               |  |  |
| 5. SEX<br>Male  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married                                       | 8. DATE OF BIRTH<br>4-5-08 | 9. AGE (In years last birthday)<br>57  | If Under 1 Yr.<br>Months Days | If Under 24 Hrs.<br>Hours Min.                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Supervisor   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Labor  |                            | 11. BIRTHPLACE (State or foreign country)<br>Pennsylvania  |                               | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br>Harry C. Anderson  |                  |   |                            | 14. MOTHER'S MAIDEN NAME<br>Beulah M. Alters   |                               |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO.<br>219-05-5139  |                            | 17. INFORMANT ADDRESS<br>Mrs. Irma W. Anderson-1155 Quantril Way-  |                               |  |  |
| 18. I 199.2 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>CAUSE OF DEATH<br>(A) Carcinoma, anaplastic, left cerebral hemisphere, origin undetermined<br>(B) DUE TO<br>(C) DUE TO<br>INTERVAL BETWEEN ONSET AND DEATH<br>8 months |                  |   |                            |  |                               |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |   |                            |  |                               |  |  |
| 19A. DATE OF OPERATION<br>8-6-64  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Brain Tumor   |                            | 20A. AUTOPSY? (Yes or No)<br>No  |                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                               |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                            | 21F. HOW DID INJURY OCCUR?   |                               |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3-22-19 65 to 4-6-19 65, that (I) (we) last saw the deceased alive on April 6, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                            |  |                               |  |  |
| 23A. SIGNATURE<br>Juri Hinno<br>(Juri Hinno)  |                  |   |                            | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                               | 23B. DATE SIGNED<br>4-7-65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Juri Hinno  |                  | 23D. ADDRESS<br>M.D. 5002 Frankford Ave.  |                            |  |                               |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4-9-65   |                            | 24C. NAME of CEMETERY or CREMATORY<br>Meadowridge Memorial Park  |                               | 24D. LOCATION (City, town, or county) (State)<br>Elkridge, Md.       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Hubbard   |                            | 25C. FUNERAL DIRECTOR ADDRESS<br>Howard H. Hubbard-4107 Wilkens Ave-21229  |                               |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                     |   |                                      |  |                              |   |  |
|---|---------------------|---|--------------------------------------|--|------------------------------|---|--|
| BIRTH NO. 65 3754   |                     | BALTIMORE CITY HEALTH DEPARTMENT  |                                      | CERTIFICATE OF DEATH X   |                              | Registered No. 65 3754  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Annvie Roberts</i>  |                     |   |                                      | 2. DATE AND HOUR OF DEATH<br><i>4/5/65</i> <i>5:30</i> a.m.  |                              |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                     |   |                                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                              |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>University Hospital</i><br><i>BALTIMORE 1, Md.</i>   |                     | (If not in hospital or institution, give street address or location)                                      |                                      | A. STATE<br><i>md</i>  |                              | B. COUNTY<br><i>Harford</i>   |  |
|   |                     |   |                                      | C. CITY OR TOWN<br><i>Whitford</i>   |                              | (If outside city limits, write RURAL and give township)<br><i>62-00</i>     |  |
|   |                     |   |                                      | O. STREET ADDRESS (If rural, give location)  |                              |   |  |
| 5. SEX<br><i>F</i>  | 6. RACE<br><i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><i>Widowed</i>                                  | 8. DATE OF BIRTH<br><i>9/22/1919</i> | 9. AGE (In years lost birthday)<br><i>46</i>   | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Domestic</i>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                      | 11. BIRTHPLACE (State or foreign country)<br><i>Va</i>   |                              | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                  |  |
| 13. FATHER'S NAME<br><i>George Meade</i>  |                     |   |                                      | 14. MOTHER'S MAIDEN NAME<br><i>UNKNOWN</i>   |                              |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>   |                     | 16. SOCIAL SECURITY NO.   |                                      | 17. INFORMANT<br><i>Charles Roberts (son)</i>  |                              | ADDRESS<br><i>Lodona, Md</i>  |  |
| 18. <i>455X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   |                                      | CAUSE OF DEATH<br>(A) <i>Gangrene rt foot</i><br>DUE TO<br>(B)<br>DUE TO<br>(C)<br>DUE TO  |                              | INTERVAL BETWEEN ONSET AND DEATH<br><i>1 week</i>                           |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |   |                                      |  |                              |   |  |
| 19A. DATE OF OPERATION<br><i>None</i>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 20A. AUTOPSY? (Yes or No)<br><i>no</i>   |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                              |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                      | 21F. HOW DID INJURY OCCUR?   |                              |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/4</i> <i>1965</i> to <i>4/5</i> <i>1965</i> , that (I) (we) last saw the deceased alive on <i>4/4</i> <i>1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (We) (did) (did not) view the body after death.          |                     |   |                                      |  |                              |   |  |
| 23A. SIGNATURE<br><i>Robert M. Pyles</i>  |                     |   |                                      | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                              | 23B. DATE SIGNED<br><i>4/5/65</i>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Robert M. Pyles</i>  |                     |   |                                      | 23D. ADDRESS<br><i>University Hospital</i>   |                              |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                     | 24B. DATE<br><i>Apr. 7, 1965</i>  |                                      | 24C. NAME of CEMETERY or CREMATORY<br><i>Bel Air Memorial Gardens</i>  |                              | 24D. LOCATION (City, town, or county) (State)<br><i>Bel Air Harford Md.</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 8 1965</i>  |                     | 25B. NAME OF REGISTRAR<br><i>R. B. E. Taylor</i>  |                                      | 25C. FUNERAL DIRECTOR<br><i>Howard K. McGonag &amp; Son</i>  |                              | ADDRESS<br><i>Abingdon Md.</i>  |  |



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 3755 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3755

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

SOPHIA PINKNEY

2. DATE AND HOUR PRONOUNCED DEAD

April 7, 1965 12:01 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

Johns Hopkins Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

Baltimore 1910 E. Madison St.

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

8-11-1905

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Va.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Joe Tomlin

14. MOTHER'S MAIDEN NAME

Lula Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Edith Pinkney 1910 E. Madison St.

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

Carcinoma of uterus with metastases

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.INTERVAL BETWEEN  
ONSET AND DEATHII  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-7-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-12-65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 8

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

George A. Klen 1348 N. Calhoun St.

24D. ADDRESS



WALTER DODGE

RECEIVED

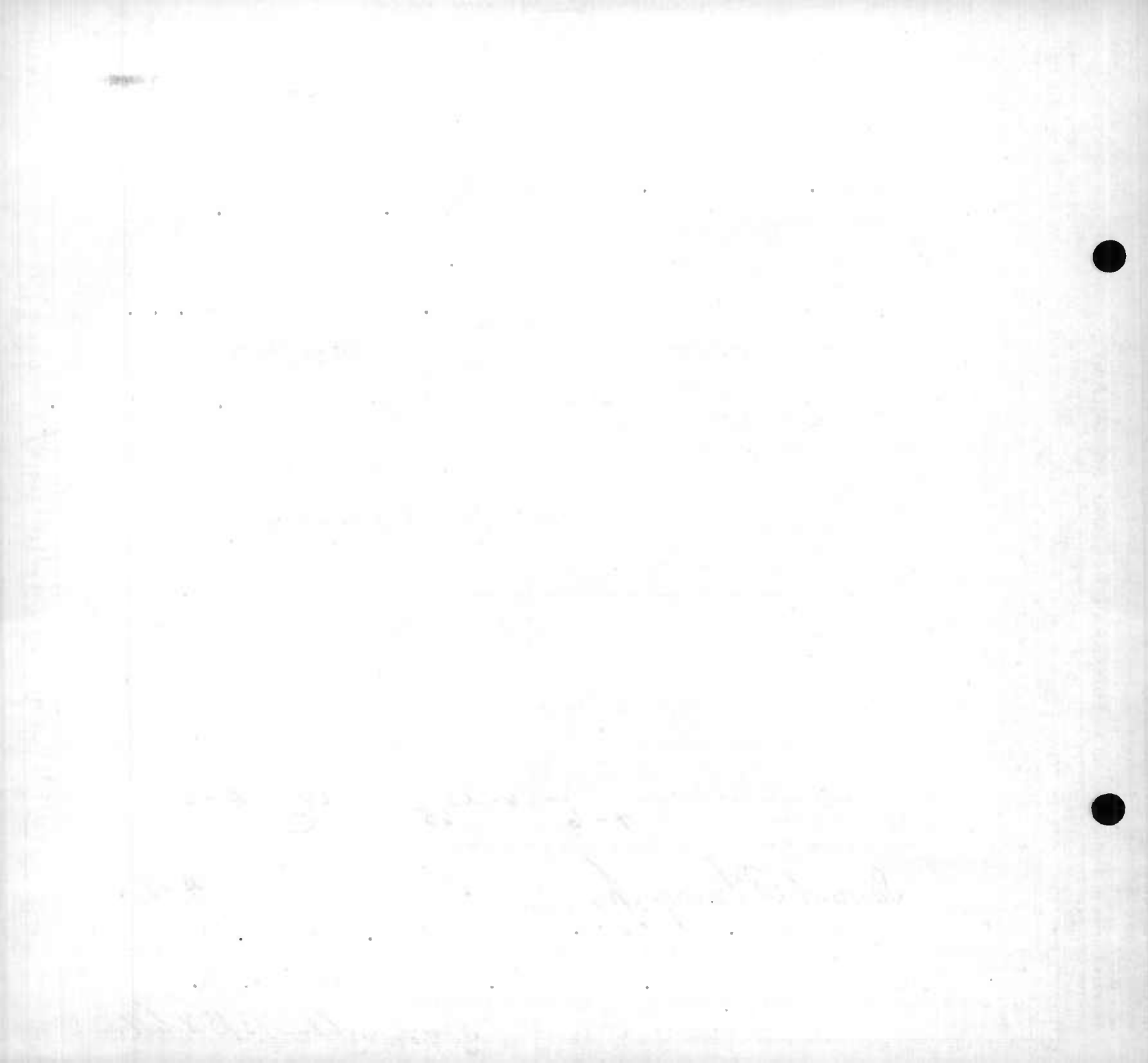
DEC 1



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

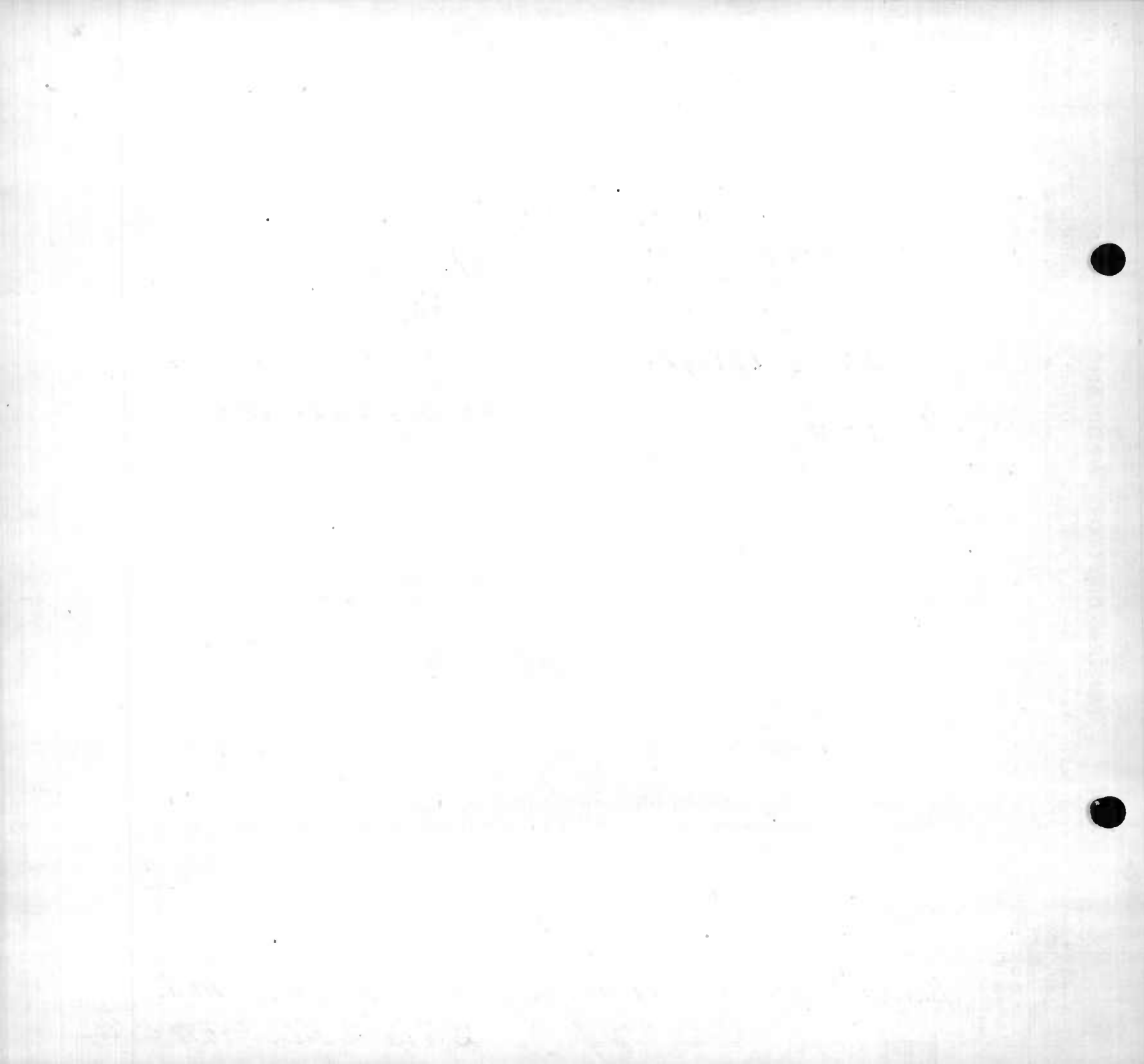
| BALTIMORE CITY HEALTH DEPARTMENT   |                  |   |   | Registered No. 65 3756   |  |
|--|------------------|---|---|--|--|
| BIRTH NO. 65 3756  |                  | M.E. CASE NO.   |   | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print) THOMAS BERRYMAN   |                  |   | 2. DATE AND HOUR OF DEATH<br>April 6, 1965 1:45 A.M.                                  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>1123 N. Stockton St.   |                  |   | A. STATE<br>Maryland  |  |  |
| (If not in hospital or institution, give street address or location)   |                  |   | B. COUNTY<br>Baltimore  |  |  |
|  |                  |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore  |  |  |
|  |                  |   | D. STREET ADDRESS (If rural, give location)<br>1123 N. Stockton St.                   |  |  |
| 5. SEX<br>Male   | 6. RACE<br>Negro | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Never married                                 | 8. DATE OF BIRTH<br>Feb. 5, 1906  | 9. AGE (In years lost birthday)<br>59                                    | 10. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  |   | 11. BIRTHPLACE (State or foreign country)<br>Va.                                      |  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |
| 13. FATHER'S NAME<br>Isaac Berryman  |                  |   | 14. MOTHER'S MAIDEN NAME<br>Susan Carey   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  |   | 16. SOCIAL SECURITY NO.<br>217-01-1031  |  |  |
| 17. INFORMANT<br>Ethel Maddox  |                  |   | ADDRESS<br>1123 N. Stockton St.   |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   | CAUSE OF DEATH<br>(A) Carcinoma of Colon<br>(B) Metastatic Carcinoma of Liver<br>(C)  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br>2 years  |                  |   |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Malnutrition   |                  |   |   |  |  |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 6-23-1964 to 4-6-1965, that (I) (we) last saw the deceased alive on 4-6-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                              |                  |   |   |  |  |
| 23A. SIGNATURE<br>Samuel R. Owings, Jr.  |                  |   |   | 23B. DATE SIGNED<br>4-8-65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Samuel R. Owings, Jr.  |                  |   |   | 23D. ADDRESS<br>909 N. Carey St.   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>4/10/65  |   | 24C. NAME OF CEMETERY or CREMATORY<br>Mt. Auburn Cem.                    |  |
| 24D. LOCATION<br>Baltimore, Md.  |                  | 24E. LOCATION (City, town, or county) (State)   |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |   | 25C. FUNERAL DIRECTOR<br>Helen H. Kline                                  |  |
| 25D. ADDRESS   |                  | 25E. ADDRESS  |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |               |   |   |  |  |
|--|---------------|---|---|--|--|
| BIRTH NO. 65 3757  |               | BALTIMORE CITY HEALTH DEPARTMENT  |   | Registered No. 65 3757   |  |
| M.E. CASE NO.  |               |   | 1. NAME OF DECEASED (Type or Print) Dallas Wright   |  |  |
| 2. DATE AND HOUR OF DEATH April 7, 1965 6:15 a. m.   |               |   | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Provident Hospital 1514 Division St. Baltimore, Maryland 21217   |               |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 16-02 C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore D. STREET ADDRESS (If rural, give location) 1104 N. Carey St. |  |  |
| 5. SEX Male  | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married  | 8. DATE OF BIRTH 5/15/89  | 9. AGE (In years lost birthday) 75   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |               | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country) Va.  |  |
| 12. CITIZEN OF WHAT COUNTRY? USA   |               |   | 13. FATHER'S NAME Dallas Wright   |  |  |
| 14. MOTHER'S MAIDEN NAME Mabel Carter  |               |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |  |  |
| 16. SOCIAL SECURITY NO.  |               |   | 17. INFORMANT Edith Wright 1104 N. Carey St   |  |  |
| 18. 420.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |               |   | CAUSE OF DEATH (A) Congestive Heart Failure Unknown (B) Anterior Myocardial Infarction Unknown (C)  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH   |               |   | II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Anterior Myocardial Infarction, Bicuspid Unknown  |  |  |
| 19A. DATE OF OPERATION 0   |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No) NO   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |               | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |               | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |   | 21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?   |               | 22. I certify that (I) (this hospital) attended the deceased from April 5, 1965 19 to April 7, 1965 19 that (I) (we) last saw the deceased alive on April 7, 1965 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |  |
| 23A. SIGNATURE Roland T. Smoot   |               |   | 23B. DATE SIGNED 4-7-65   |  |  |
| 23C. PHYSICIAN'S NAME (Type) Roland T. Smoot   |               |   | 23D. ADDRESS 1514 Division St.  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |               | 24B. DATE 4-10-65   |   | 24C. NAME OF CEMETERY or CREMATORY Arboretus Mem. Pk.  |  |
| 24D. LOCATION (City, town, or county) (State) Arbutus, Md.   |               | 25A. DATE REC'D BY HEALTH DEPT. APR 8 1965  |   | 25B. NAME OF REGISTRAR Robert S. Taylor  |  |
| 25C. FUNERAL DIRECTOR George B. Kilmer   |               | 25D. ADDRESS 1348 N. Calhoun St   |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |
|--|--|-------------------------|--|--|--|------------------------------------|--|--|--|---|--|------------------------------|---|--|
| BIRTH NO. 65 3758  |  |                         |  |  | CERTIFICATE OF DEATH   |                                    |  |  |  | Registered No. 65 3758  |  |                              |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Jerome Kemp Kuebel</b>   |  |                         |  |  | 2. DATE AND HOUR OF DEATH<br><b>4-6-65 11 40 P.M.</b>  |                                    |  |  |  |   |  |                              |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |                         |  |  |  |                                    |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)       |  |                              |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Union Memorial Hospital</b>   |  |                         |  |  | (If not in hospital or institution, give street address or location)                                   |                                    |  |  |  | A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>   |  |                              |   |  |
|  |  |                         |  |  |  |                                    |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b> |  |                              |   |  |
|  |  |                         |  |  |  |                                    |  |  |  | D. STREET ADDRESS (If rural, give location)<br><b>300 A. E. University Pkwy</b>             |  |                              |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. RACE<br><b>White</b> |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b> |  | 8. DATE OF BIRTH<br><b>11-3-97</b> |  | 9. AGE (In years last birthday)<br><b>67</b> |  | 11. Under 1 Yr. Months Days   |  | 12. Under 24 Hrs. Hours Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |  |                         |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Cashier</b>  |                                    |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                |  |                              |   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |                         |  |  | 13. FATHER'S NAME<br><b>Joseph A. Kuebel</b>   |                                    |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Lida Kemp</b>  |  |                              |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |                         |  |  | 16. SOCIAL SECURITY NO.<br><b>212-01-7261</b>  |                                    |  |  |  | 17. INFORMANT<br><b>Mrs. Josie C. Kuebel Balto., Md.</b>                                    |  |                              |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary Edema</b>   |  |                         |  |  | CAUSE OF DEATH<br>(A) DUE TO<br><b>Branchogenic Ca. (C Metastasis)</b>                                 |                                    |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10-12 hours</b>                                      |  |                              |   |  |
| 18. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  |                         |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |  |  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  |                              |   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |                         |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                    |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                    |  |                              |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |                         |  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    |  |  |  | 21F. HOW DID INJURY OCCUR?  |  |                              |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-6-65</b> to <b>4-6-65</b> , that (I) (we) last saw the deceased alive on <b>4-6-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |
| 23A. SIGNATURE<br><b>Rodney L. Brimhall</b> M.D.   |  |                         |  |  |  |                                    |  |  |  | 23B. DATE SIGNED<br><b>4-6-65</b>   |  |                              | 23C. PHYSICIAN'S NAME (Type)<br><b>RODNEY L. BRIMHALL</b> |  |
| 23D. ADDRESS<br><b>Union Memorial Hospital</b> M.D.  |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |
| 24A. BURIAL REMOVAL (Specify)<br><b>Burial</b>   |  |                         |  |  | 24B. DATE<br><b>4/10/1965</b>  |                                    |  |  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Druid Ridge Cemetery</b>                           |  |                              |   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Pikesville, Maryland</b>   |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |  |                         |  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |                                    |  |  |  | 25C. FUNERAL DIRECTOR<br><b>Wm. J. Tidwell</b>  |  |                              |   |  |
| ADDRESS<br><b>Balto., Md. 21217 North &amp; pa. Aves.</b>  |  |                         |  |  |  |                                    |  |  |  |   |  |                              |   |  |



| 65 3759   |         | BALTIMORE CITY HEALTH DEPARTMENT   |   | 65 3759  |   |
|---|---------|--|---|--|---|
| BIRTH NO. 6582541   |         | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.                                   |   |  |   |
| M.E. CASE NO.   |         |  |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  | 2. DATE AND HOUR PRONOUNCED DEAD  |  |   |
| CONSTANCE GREEN   |         |  | April 6, 1965 3:20 p.m.   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |  | A. STATE<br>Maryland  |  |   |
| South Baltimore Hospital  |         |  | B. COUNTY<br>Baltimore  |  |   |
| C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)  |         |  | D. STREET ADDRESS (If rural, give location)   |  |   |
| 25-33   |         |  | 2621 Maisel St.   |  |   |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)                                 | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | 10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| female  | colored |  | 1/27/65   | 2  |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |   |
| Child   |         |  |   | Maryland   |   |
| 13. FATHER'S NAME   |         |  | 14. MOTHER'S MAIDEN NAME  |  |   |
| Victor Johnson  |         |  | Deborah Green   |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |
|   |         |  |   | Constance E. Green 2621 Maisel St.                                       |   |
| 18. CAUSE OF DEATH  |         |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  | (A) DUE TO  |  |   |
| INTERSTITIAL PNEUMONITIS  |         |  |   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |         |  | (B) DUE TO  |  |   |
|   |         |  | (C) DUE TO  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |   |  |   |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
| 3   |         |  |   | Yes  |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH?  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
|   |         |  |   |  |   |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?   |   |
| (Month) (Day) (Year) (Hour)   |         | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>        |   |  |   |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |   |  |   |
| ACTUAL SIGNATURE  |         | M.D.   |   | CHIEF MEDICAL EXAMINER <input type="checkbox"/>                          |   |
| EXAMINER'S NAME (Type)  |         | Rudiger Breitenecker   |   | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>           |   |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>   |         |  |   | DATE SIGNED 4-7-65   |   |
| 23A. BURIAL CREMATION, REMOVAL (Specify)  |         | 23B. DATE  |   | 23C. NAME of CEMETERY or CREMATORY                                       |   |
| Burial  |         | 4/9/65   |   | Mt Auburn  |   |
| 24A. DATE REC'D BY HEALTH DEPT.   |         | 24B. NAME OF REGISTRAR   |   | 24C. FUNERAL DIRECTOR ADDRESS  |   |
| APR 8 1965  |         | Robert E. Taylor M.D.  |   | Charles A. Rice 661 W. Barro St.   |   |

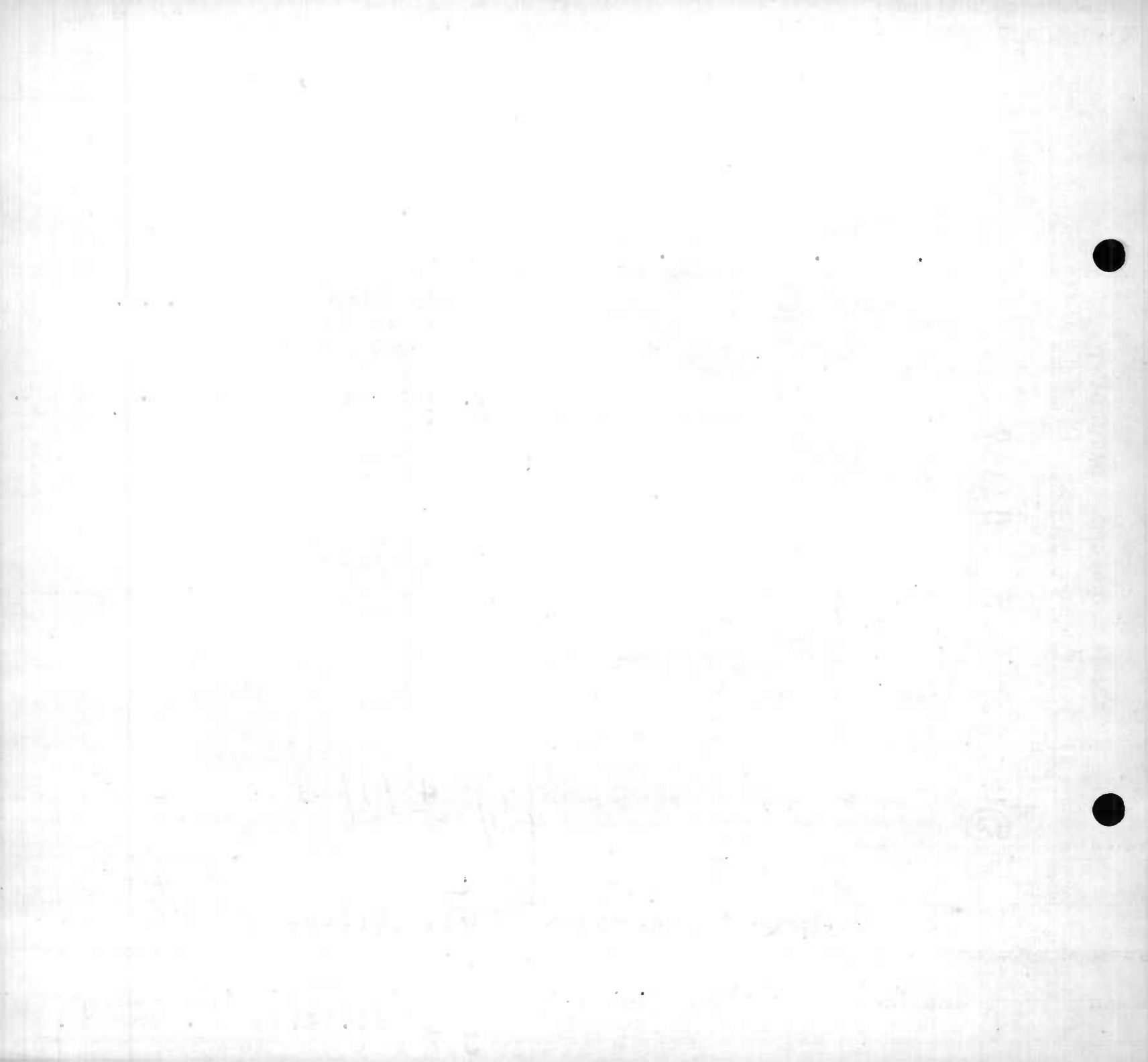
VALLEY FORTRESS



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                      |  |   |  |   |
|--|----------------------|--|---|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT   |                      | 65 3760  |   | 65 3760  |   |
| BIRTH NO. 65 3760  |                      | M.E. CASE NO.  |   | Registered No.   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Eula Davenport Hughes</b>  |                      |  | 2. DATE AND HOUR OF DEATH<br><b>April 6, 1965</b>   |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)       |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>University Hospital</b>   |                      |  | A. STATE <b>Maryland</b><br>B. COUNTY <b>2101</b>   |  |   |
| (If not in hospital or institution, give street address or location)   |                      |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b> |  |   |
| D. STREET ADDRESS (If rural, give location)<br><b>1016 W. Barre Street</b>   |                      |  | M.  |  |   |
| 5. SEX<br><b>F.</b>  | 6. RACE<br><b>C.</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>M.</b>                                  | 8. DATE OF BIRTH<br><b>4/28/05</b>  | 9. AGE (In years last birthday)<br><b>59</b>   | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>House wife</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                      | 13. FATHER'S NAME<br><b>Lue llen Davenport</b>   |   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Margaret Parker</b>   |                      |  |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |   |
| 16. SOCIAL SECURITY NO.  |                      |  |   | 17. INFORMANT<br><b>J. Jonathan Hughes</b>   |   |
| ADDRESS<br><b>s 1016 W. Barre St.</b>  |                      |  |   | 18. <b>443X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) <b>HYPERTENSIVE CARDIOVASCULAR DLSI</b><br>(B) DUE TO<br>(C) DUE TO |   |
| INTERVAL BETWEEN ONSET AND DEATH   |                      |  |   | 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/1/1965</b> to <b>4/6/1965</b> , that (I) (we) last saw the deceased alive on <b>4/1/1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |  |   |  |   |
| 23A. SIGNATURE<br><b>John S. Brantford Jr.</b>   |                      |  |   | 23B. DATE SIGNED<br><b>4/8/65</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JOHN S. BRANTFORD JR.</b>   |                      |  |   | 23D. ADDRESS<br><b>922 S. SHARP ST., BALW. 30, MD.</b>   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                      | 24B. DATE<br><b>4/9/65</b>   |   | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Auburn</b>  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>  |                      | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |   |  |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |                      |  |   | 25C. FUNERAL DIRECTOR<br><b>Charles A. Rice</b>  |   |
| ADDRESS<br><b>661 W. Barre St.</b>   |                      |  |   | VS 150-REV. 1/1/65   |   |



65 3761

BALTIMORE CITY HEALTH DEPARTMENT

65 3761

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

PHILLIP J. LEVRONEY (Carter)

2. DATE AND HOUR PRONOUNCED DEAD

April 5, 1965

9:30 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

SOUTH BALTIMORE GENERAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

A. A. G.

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

350 Snowhill Road

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)

18

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

A. A. G. Md

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18. E 981X 1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of chest  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

gas station

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Cedar Hill Road &amp; Ritchie Highway

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

4 5 65 9:20

21E. INJURY OCCURRED

WHILE AT WORK

NOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Shot during altercation

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/12/1965

23C. NAME OF CEMETERY or CREMATORY

Baltimore National Cemetery

23D. LOCATION

(City, town, or county)

Baltimore

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 8 1965

Robert E. Taylor, M.D.

Elmer C. Wilson 1072 Brantley Ave

VALLEY DRUGS

ONE COMPANY

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                     |  |                                     |   |  |
|--|---------------------|--|-------------------------------------|---|--|
| BIRTH NO. <b>65 3762</b>   |                     | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>  |                                     | Registered No. <b>65 3762</b>   |  |
| M.E. CASE NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>Mr. Clyde A. Craig</b>   |                                     | 2. DATE AND HOUR OF DEATH<br><b>4-6-65 8.25 p.m.</b>  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1601</b> |                                     | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore #17</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Montebello State Hospital</b>   |                     | D. STREET ADDRESS (If rural, give location)<br><b>1007 Carrollton Ave</b>  |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>C</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>M</b>   | 8. DATE OF BIRTH<br><b>2-6-1904</b> | 9. AGE (In years last birthday)<br><b>61</b>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Painter</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>                                  |  |
| 13. FATHER'S NAME<br><b>John Craig</b>   |                     | 14. MOTHER'S MAIDEN NAME<br><b>C Bayne</b>   |                                     | 17. INFORMANT ADDRESS<br><b>Montebello S. Hosp.</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     | 16. SOCIAL SECURITY NO.  |                                     | 17. INFORMANT ADDRESS   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Squamous Cell Carcinoma of Larynx with Metastasis to Neck and Lungs</b>   |                     | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO   |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><b>May 1964 - 4-6-65</b>                                    |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |  |                                     |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     | 20A. AUTOPSY? (Yes or No)<br><b>YES.</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                        |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                  |                                     | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3-2-1965</b> to <b>4-6-1965</b> , that (I) (we) last saw the deceased alive on <b>4-6-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |  |                                     |   |  |
| 23A. SIGNATURE<br><b>Orlando E. Ramos</b>  |                     | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>       |                                     | 23B. DATE SIGNED<br><b>4-6-65</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Orlando E. Ramos</b>  |                     | 23D. ADDRESS<br><b>Montebello S. Hosp</b>  |                                     |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Buried</b>  |                     | 24B. DATE<br><b>4/10/1965</b>  |                                     | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt Auburn Cemt</b>                                     |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |                                     |   |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Stokely</b>   |                     | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Clyde A. Wilson, 1000 Beauty Ave</b>   |                                     |   |  |

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**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |  | Certificate of Death  |  | Registered No. <span style="float: right;">65 3763</span>                          |  |
|--|-------------------------|---|--|---|--|--|--|
| BIRTH NO. <span style="float: right;">65 3763</span>   |                         | M.E. CASE NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>DOUGLAS, CHARLES J.</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>4/4/65 6:00 AM.</b>                                |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>VETERANS ADMINISTRATION HOSPITAL<br/>3900 LOCH RAVEN BLVD.<br/>BALTIMORE, MARYLAND 21218</b>   |                         |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b>                                 |  |  |  |
|  |                         |   |  | D. STREET ADDRESS (If rural, give location)<br><b>1437 E. EAGER ST.</b>   |  |  |  |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>NEGRO</b> | 7. MARRIED, NEVER MARRIED<br><b>NEVER MARRIED</b>   |  | B. DATE OF BIRTH<br><b>1/1/95</b>   | 9. AGE (In years lost birthday) <b>69 70</b> | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LABORER</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>UNKNOWN</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>WASHINGTON, D. C.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>                                    |  |
| 13. FATHER'S NAME<br><b>JOHN HENRY DOUGLAS</b>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNIE BROWN</b>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES 1/17 TO 8/17</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>32016902</b>  |  | 17. INFORMANT<br><b>VA HOSPITAL RECORDS<br/>BALTIMORE, MD. 21218</b>  |  | ADDRESS  |  |
| 18. <b>4221110021</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |   |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
|  |                         |   |  | (A) <b>Cerebral Vascular Accident</b><br>DUE TO<br><b>Generalized Arteriosclerotic Cardiovascular Disease</b>               |  | <b>2 years</b>   |  |
|  |                         |   |  | (B) <b>Cardiovascular Disease</b><br>DUE TO   |  | <b>Unknown</b>   |  |
|  |                         |   |  | (C)   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Tuberculosis, Pulmonary Pneumonia</b>   |                         |   |  |   |  | <b>4 months 2 weeks</b>  |  |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>March 25, 1965</b> to <b>April 4, 1965</b> , that (X) (we) lost saw the deceased alive on <b>April 4, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.                         |                         |   |  |   |  |  |  |
| 23A. SIGNATURE<br><i>Robert N. DiSimone</i>  |                         |   |  |   |  | 23B. DATE SIGNED<br><b>4/6/65</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROBERT N. DISIMONE</b>  |                         |   |  | 23D. ADDRESS<br><b>VA Hospital, 3900 Loch Raven Blvd<br/>Baltimore, Maryland 21218</b>                                      |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4/8/65</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto Natl Cem</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto Md</b>                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |  | 25C. FUNERAL DIRECTOR<br><i>Choy C. Wilson</i>  |  | ADDRESS  |  |

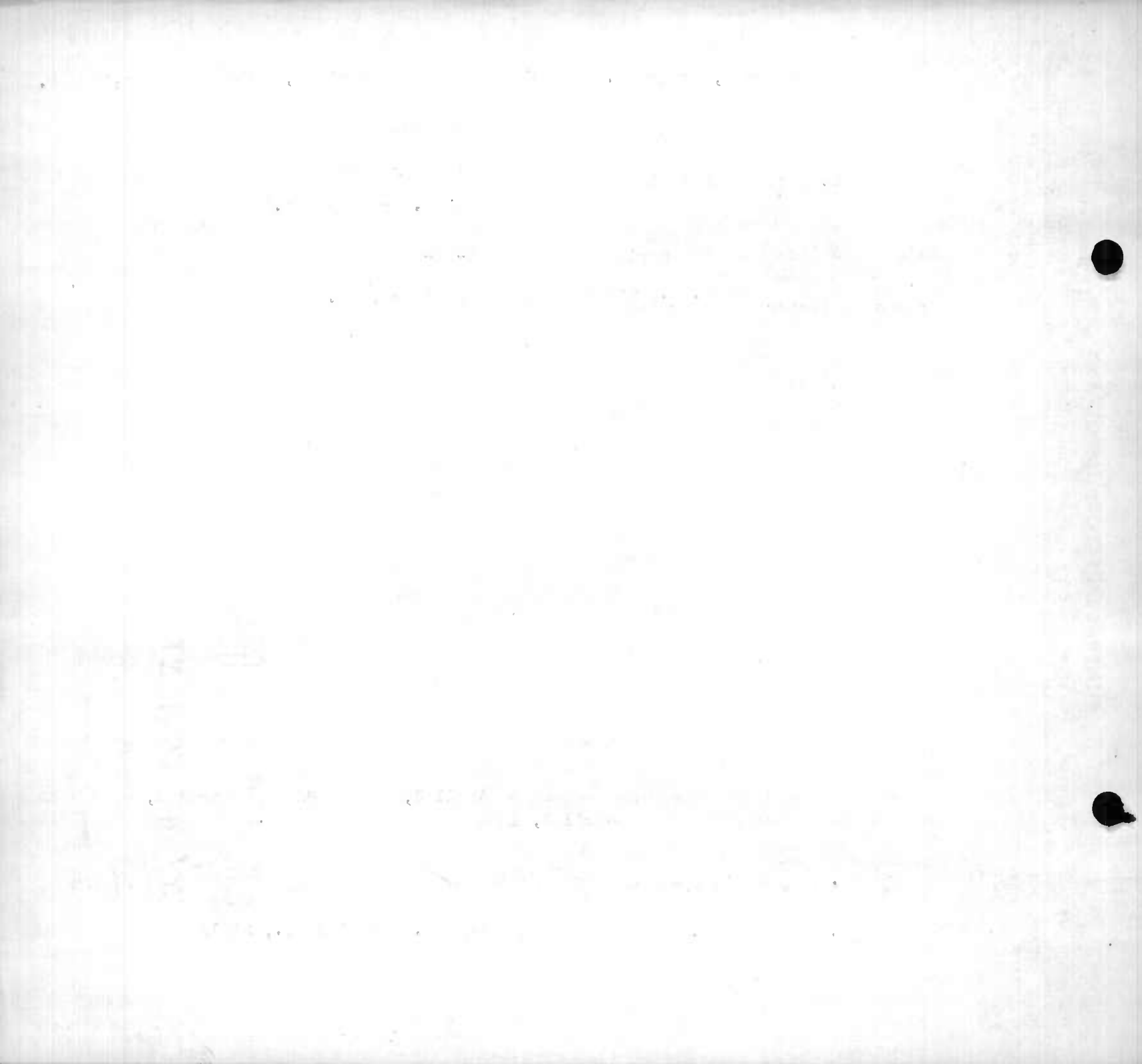
Wm. M. D. Jones



# FUNERAL DIRECTOR: IMPORTANT

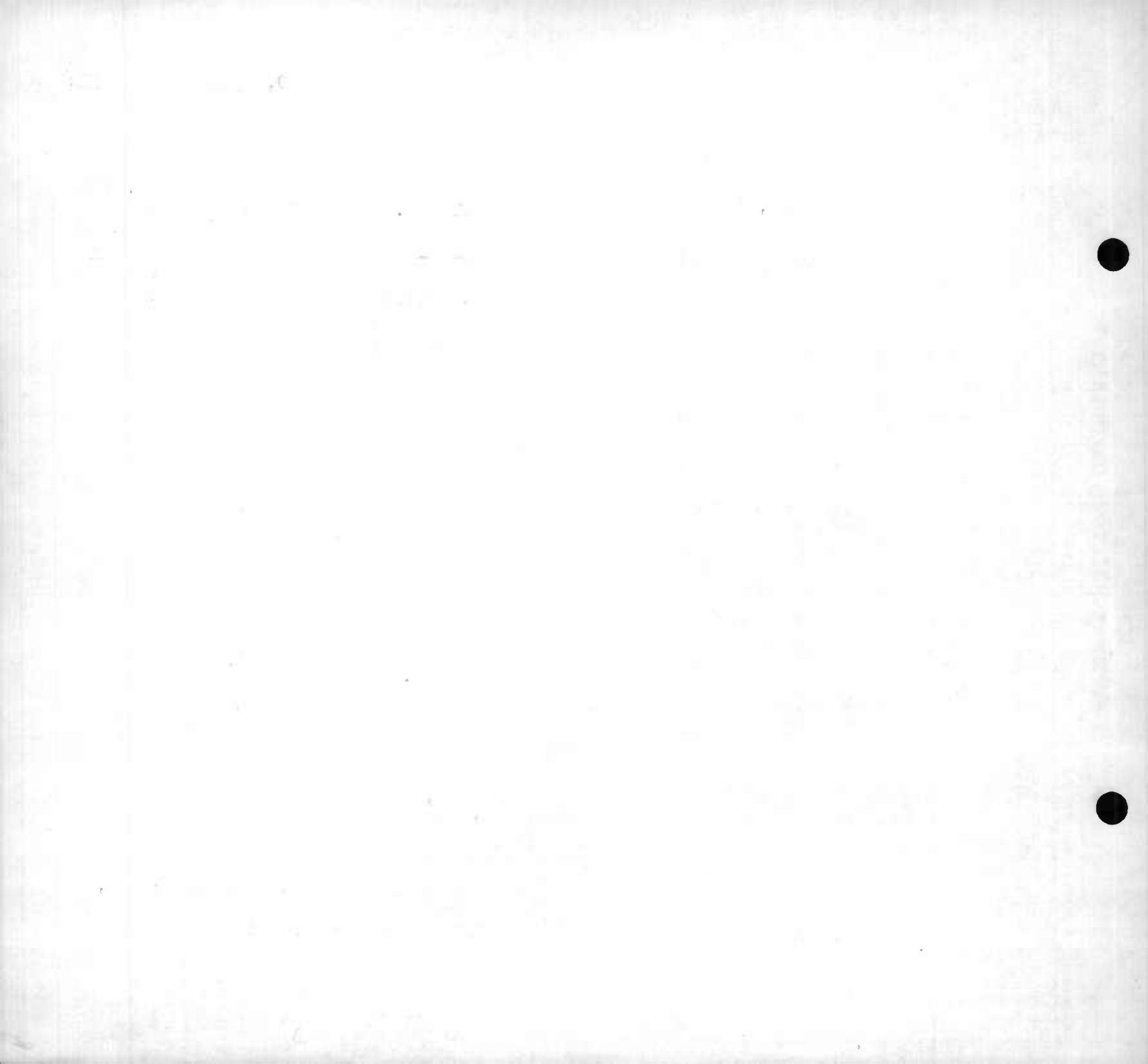
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |   |   |                                    |  |  |  |   |  |                             |  |  |
|--|--|--|--|---|---|------------------------------------|--|--|--|---|--|-----------------------------|--|--|
| BIRTH NO. 65 3764  |  |  |  |   | CERTIFICATE OF DEATH  |                                    |  |  |  | Registered No. 65 3764  |  |                             |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Pazourek, Gerard C.</b>   |  |  |  |   | 2. DATE AND HOUR OF DEATH<br><b>April 3, 1965</b>   |                                    |  |  |  | 4:15 P. M.  |  |                             |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Joseph Hospital</b>  |  |  |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>603</b> |                                    |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore #24</b> |  |                             |  |  |
|  |  |  |  |   | D. STREET ADDRESS (If rural, give location)<br><b>417 N. Bradford St.</b>   |                                    |  |  |  |   |  |                             |  |  |
| 5. SEX<br><b>Male</b>  |  | 6. RACE<br><b>White</b>                          |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>                                |   | 8. DATE OF BIRTH<br><b>3-11-09</b> |  | 9. AGE (In years last birthday)<br><b>56</b>                         |  | If Under 1 Yr. Months Days  |  | If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Customs Collector</b>  |  |  |  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Custom Service</b>  |                                    |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>                              |  |                             |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  |  |  |   | 13. FATHER'S NAME<br><b>JAMES PAZOUREK</b>  |                                    |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNA BLAHA</b>   |  |                             |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |  |  |   | 16. SOCIAL SECURITY NO.   |                                    |  |  |  | 17. INFORMANT ADDRESS<br><b>Mrs. Elizabeth M. Pazourek - 417 N. Bradford St.</b>                |  |                             |  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>162.1 I</b><br><b>Bronchiogenic carcinoma left lung with generalized metastasis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |  |  |   |   |                                    |  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |                             |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |                                    |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |                             |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |   |  |                             |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   |                                    | 21F. HOW DID INJURY OCCUR?   |  |  |   |  |                             |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 3, 1965</b> to <b>April 3, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 3, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |  |  |   |   |                                    |  |  |  |   |  |                             |  |  |
| 23A. SIGNATURE<br><b>E. C. Flanigan Jr.</b><br>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  |  |  |   |   |                                    |  |  |  | 23B. DATE SIGNED<br><b>4/3/65</b>   |  |                             |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Edward A. Flanigan Jr.</b>  |  |  |  |   | 23D. ADDRESS<br>M.D. <b>1400 N. Caroline St., 21213</b>   |                                    |  |  |  |   |  |                             |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>4-7-65</b>                       |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>HOLY REDEMMER CEM.</b>   |   |                                    | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO., MD.</b>      |  |  |   |  |                             |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |  |  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Stasko</b>   |   |                                    |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>2334 Jefferson St</b>            |  |   |  |                             |  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |   |   |   |  |                       |
|---|------------------|---|---|---|---|--|-----------------------|
| BIRTH NO. <u>65-07162</u>   |                  | 65 3766   |   | BALTIMORE CITY HEALTH DEPARTMENT  |   | Registered No. <u>65 3766</u>  |                       |
| M.E. CASE NO.   |                  |   |   | 1. NAME OF DECEASED<br>(Type or Print) <u>RAMSEY, BABY BOY</u>  |   |  |                       |
| 2. DATE AND HOUR OF DEATH<br><u>3-31-65</u> <u>5:55 P.M.</u>  |                  |   |   |   |   |  |                       |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |   |  |                       |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Church Home &amp; Hospital</u>  |                  |   |   | A. STATE <u>Maryland</u> B. COUNTY <u>26-34</u>   |   |  |                       |
|   |                  |   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>Baltimore 5</u>                                   |   |  |                       |
|   |                  |   |   | D. STREET ADDRESS (If rural, give location)<br><u>1001 Quantrel Way</u>   |   |  |                       |
| 5. SEX <u>M</u>   | 6. RACE <u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><u>new born</u>                                 | 8. DATE OF BIRTH<br><u>3-30-65</u>  | 9. AGE (In years last birthday)   | If Under 1 Yr. Months: Days: Hours: Min.                |  | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Infant</u>  |                  |   | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>              |  |                       |
| 13. FATHER'S NAME<br><u>Billy Ramsey</u>  |                  |   | 14. MOTHER'S MAIDEN NAME<br><u>Shirley Rose</u>                                       |   |   |  |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  |   | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><u>Billy Ramsey 1001 Quantrel Way</u>  |   |  |                       |
| 18. <u>776X I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   | CAUSE OF DEATH<br>(A) <u>Immaturity</u><br>DUE TO<br>(B) _____<br>DUE TO<br>(C) _____ |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 1/2 hours</u> |  |                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |   |   |   |   |  |                       |
| 19A. DATE OF OPERATION<br><u>0</u>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><u>No</u>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |   |  |                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |  |                       |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-30-65</u> 19 to <u>3-31-65</u> 19 that (I) (we) last saw the deceased alive on <u>3-31-65</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                          |                  |   |   |   |   |  |                       |
| 23A. SIGNATURE<br><u>Cesar R. Bariso</u> M.D.   |                  |   |   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED<br><u>4-2-65</u>                                    |                       |
| 23C. PHYSICIAN'S NAME (Type)<br><u>CESAR R. BARISO, M.D.</u>  |                  |   |   | 23D. ADDRESS<br><u>Church Home &amp; Hosp. Balto. Md</u>  |   |  |                       |
| 24A. BURIAL CREMATION DATE<br>REMOVAL (Specify) <u>APR 6 1965</u>   |                  | 24B. NAME OF CEMETERY or CREMATORY<br><u>ANATOMY BOARD</u>  |   | 24C. LOCATION (City, town, or county) (State)   |   |  |                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 8 1965</u>  |                  | 25B. NAME OF REGISTRAR<br><u>Robert E. Farley</u>   |   | 25C. FUNERAL DIRECTOR MEDICAL SCHOOL ADDRESS<br><u>MORTUARY SERVICE - BCHD</u>  |   |  |                       |

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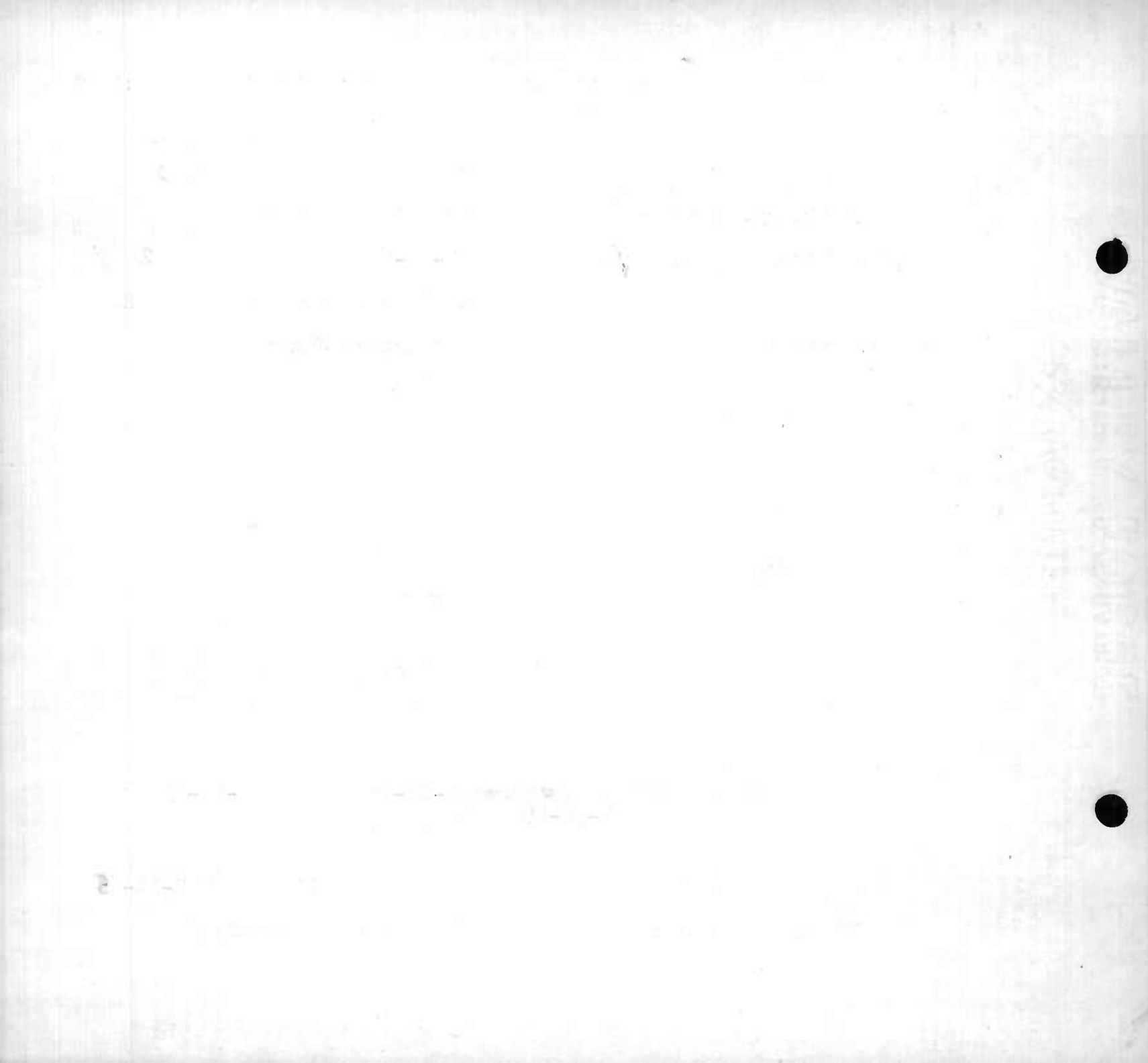
24-01-02

24-01-02

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

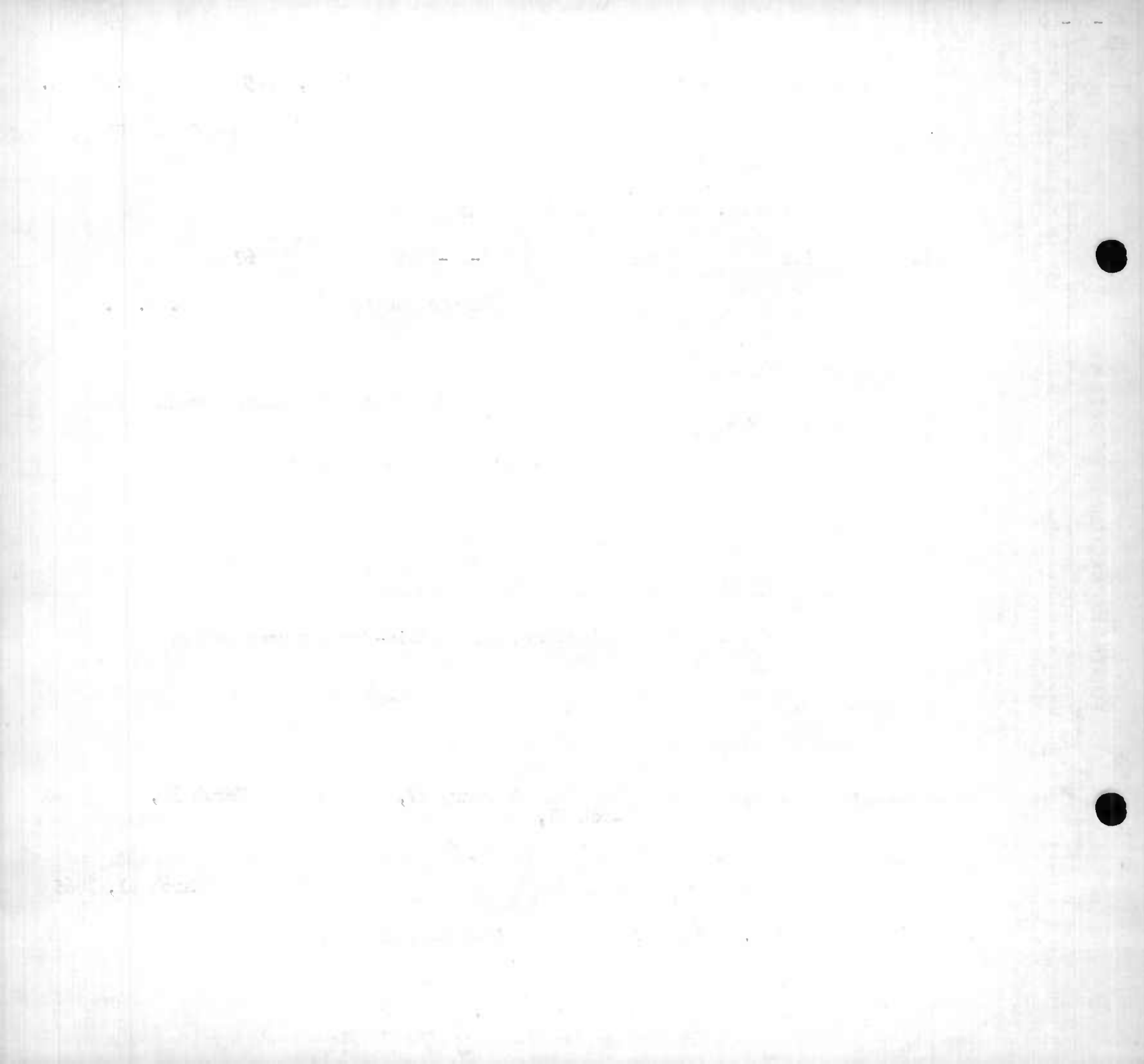
|  |         |  |                  |  |  |
|--|---------|--|------------------|--|--|
| BIRTH NO. <u>65 3767</u>   |         | BALTIMORE CITY HEALTH DEPARTMENT   |                  | Registered No. <u>65 3767</u>  |  |
| M.E. CASE NO.  |         | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE AND HOUR OF DEATH  |  |
|  |         | Baby of Florence Watkins   |                  | March 30, 1965   5:30 A. M.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |         | A. STATE<br>B. COUNTY  |                  |  |  |
| Provident Hospital<br>1514 Division Street<br>Baltimore, Maryland  |         | Maryland   |                  |  |  |
|  |         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |                  |  |  |
|  |         | Churchton  |                  |  |  |
|  |         | D. STREET ADDRESS (If rural, give location)  |                  |  |  |
|  |         | Churchton, Maryland  |                  |  |  |
| 5. SEX   | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | If Under 1 Yr. Months: Days: Hours: Min. |
| Female   | Negro   | Single   | 3-28-65          |  | 2 8                                      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |  |
|  |         |  |                  | Baltimore, Maryland  |  |
| 13. FATHER'S NAME  |         | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| George Watkins   |         | Florence James   |                  | USA  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |  |
|  |         |  |                  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |         | CAUSE OF DEATH   |                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 762.5 I  |         | (A) DUE TO   |                  | Cerebral Hemorrhage  |  |
| ANTECEDENT CAUSES  |         | (B) DUE TO   |                  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         | (C) DUE TO   |                  | Pneumonia  |  |
| II   |         |  |                  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |         |  |                  |  |  |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |  |
| 2  |         |  |                  | yes.   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |         |  |                  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/>   |                  | 21F. HOW DID INJURY OCCUR?   |  |
|  |         |  |                  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 3-28-65 19 to 3-30-65 19, that (I) (we) last saw the deceased alive on 3-30-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |  |  |
| 23A. SIGNATURE   |         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                  | 23B. DATE SIGNED   |  |
| Vincent R. Blake   |         |  |                  | 3-31-65  |  |
| 23C. PHYSICIAN'S NAME (Type)   |         | 23D. ADDRESS   |                  |  |  |
| Vincent R. Blake   |         | 1514 Division Street   |                  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE  |                  | 24C. NAME of CEMETERY or CREMATORY                                       |  |
|  |         | APR 6 1965   |                  | ANATOMY BOARD OF MARYLAND  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS  |  |
| APR 8 1965   |         | R. A. B. F. Blake  |                  | UNIVERSITY MEDICAL SCHOOL  |  |
| MORTUARY SERVICE - BCHD  |         |  |                  |  |  |





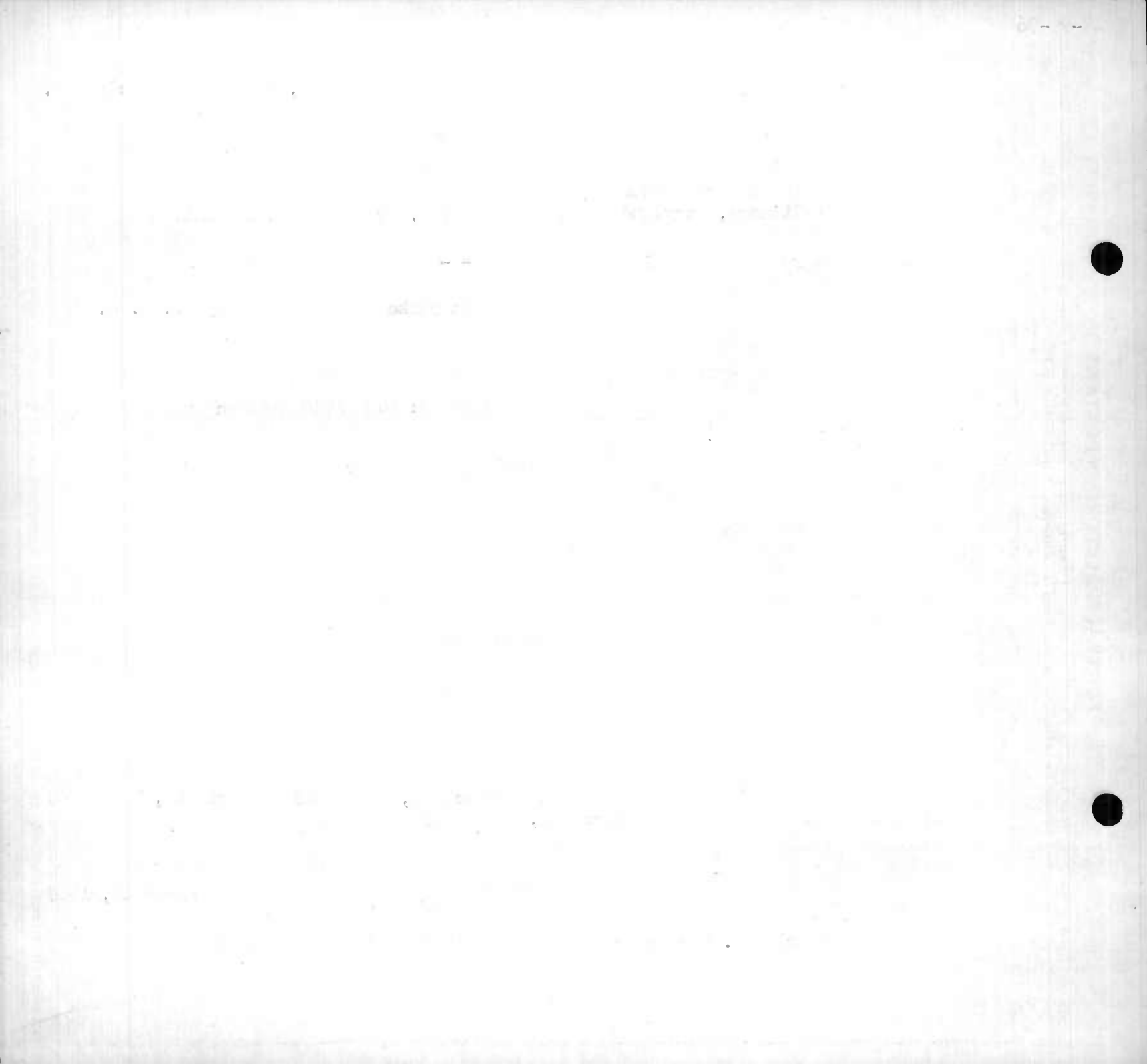
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3768   |                  |   |                               | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3768   |  |
|---|------------------|---|-------------------------------|--|--|--|--|
| M.E. CASE NO.   |                  |   |                               | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) John Joseph Hayden   |                  |   |                               | 2. DATE AND HOUR OF DEATH<br>March 31, 1965 10:45 A. M.  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224   |                  |   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>Homeless |  |  |  |
| 5. SEX<br>Male  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Separated                                     | 8. DATE OF BIRTH<br>2-12-1898 | 9. AGE (In years<br>lost birthday)<br>67   | If Under 1 Yr. Months: Days: Hours: Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                               | 11. BIRTHPLACE (State or foreign country)<br>Massachusetts   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                             |  |
| 13. FATHER'S NAME   |                  |   |                               | 14. MOTHER'S MAIDEN NAME   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.   |                               | 17. INFORMANT ADDRESS<br>RECORDS: BCH 4940 Eastern Avenue 21224  |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Pulmonary Tuberculosis-Far Advanced Active |                  |   |                               | CAUSE OF DEATH<br>(A) Arteriosclerotic Heart Disease<br>DUE TO<br>(B) DUE TO<br>(C) DUE TO   |  | INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                               | 20A. AUTOPSY? (Yes or No)<br>No  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                               | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from February 27, 19 65 to March 31, 19 65, that (I) (we) last saw the deceased alive on March 31, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |   |                               |  |  |  |  |
| 23A. SIGNATURE<br>Charles C. Carpenter  |                  |   |                               | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED<br>March 31, 1965                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Charles C. Carpenter  |                  |   |                               | 23D. ADDRESS<br>M.D. 4940 Eastern Avenue 21224   |  |  |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br>APR 8 1965   |                  | 24B. NAME OF CEMETERY or CREMATORY<br>JOHNS HOPKINS MEDICAL SCHOOL  |                               | 24C. LOCATION (City, town, or county, State)<br>BALTIMORE, MARYLAND  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                               | 25C. FUNERAL DIRECTOR<br>MORTUARY SERVICE - BCHD   |  |  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

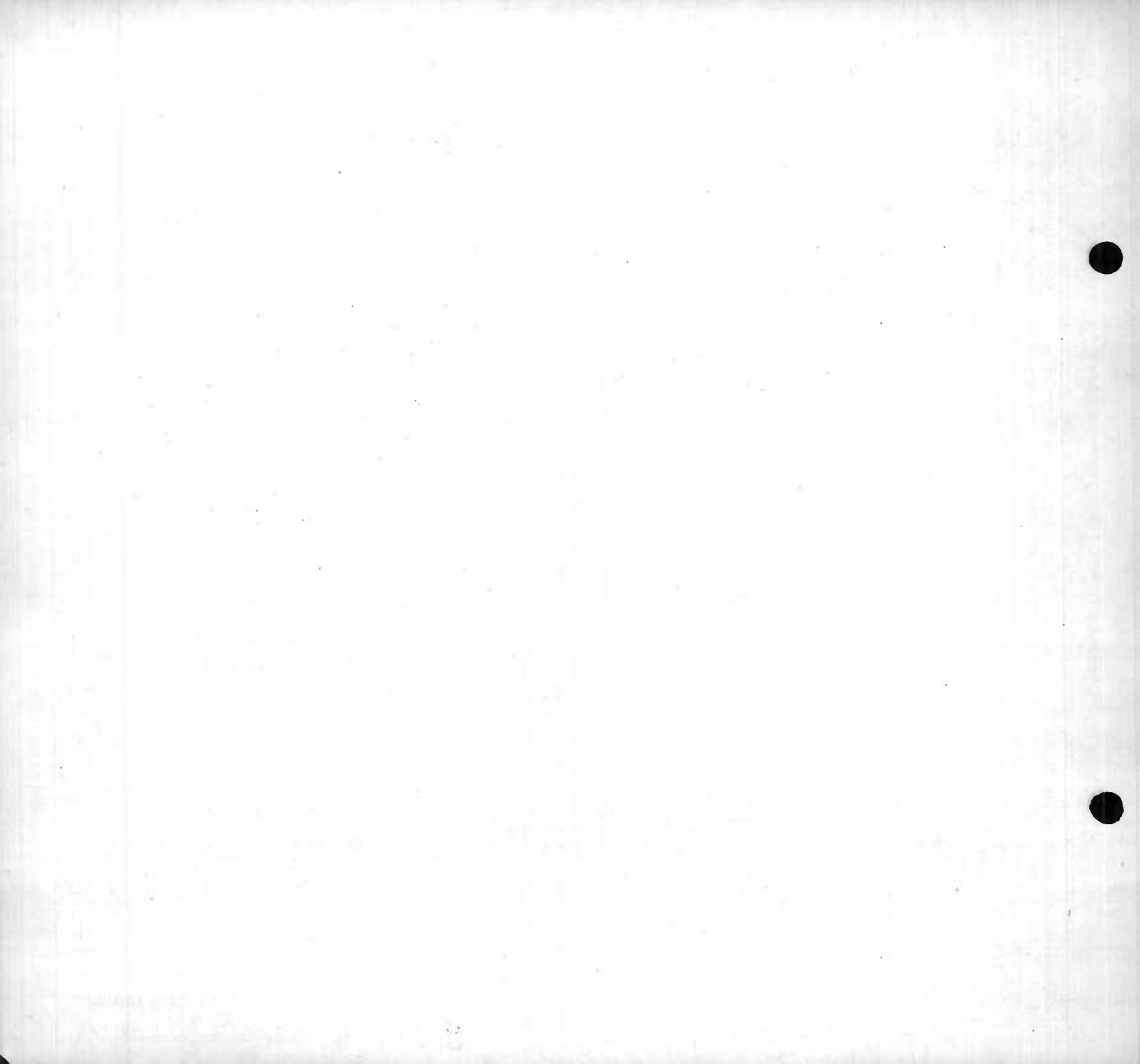
|   |  |  |   |  |  |
|---|--|--|---|--|--|
| BIRTH NO. 65 3769   |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3769   |  |
| M.E. CASE NO.   |  |  | 1. NAME OF DECEASED (Type or Print) Frank Sherman   |  |  |
| 2. DATE AND HOUR OF DEATH March 24, 1965 1:15 P. M.   |  |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore |  |  |
| 5. SEX Male   |  |  | 6. RACE Negro   |  |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Single   |  |  | 8. DATE OF BIRTH 1-1-1885   |  |  |
| 9. AGE (In years lost birthday) 80  |  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)                                  |  |  |
| 11. BIRTHPLACE (State or foreign country) Nebraska  |  |  | 12. CITIZEN OF WHAT COUNTRY? U. S. A.   |  |  |
| 13. FATHER'S NAME   |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  | 16. SOCIAL SECURITY NO.   |  |  |
| 17. INFORMANT ADDRESS RECORDS: BCH 4940 Eastern Avenue 21224  |  |  | 18. CAUSE OF DEATH  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  |  | (A) Carcinoma of Stomach DUE TO   |  |  |
| ANTECEDENT CAUSES   |  |  | (B) DUE TO  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  | (C)   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Aspiration  |  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 22, 19 65 to March 24, 19 65, that (I) (we) last saw the deceased alive on March 24, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |   |  |  |
| 23A. SIGNATURE Charles C. Carpenter   |  |  |   | 23B. DATE SIGNED March 24, 1965  |  |
| 23C. PHYSICIAN'S NAME (Type) Charles C. Carpenter   |  |  |   | 23D. ADDRESS 4940 Eastern Avenue 21224                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) APR 8 1965   |  | 24B. NAME OF CEMETERY or CREMATORY   |   | 24D. LOCATION (City, town, or county) (State)                            |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 8 1965  |  | 25B. NAME OF REGISTRAR Robert E. Estabrook   |   | 25C. FUNERAL DIRECTOR ADDRESS 3 MORTUARY SERVICE - BCHD                  |  |



# FUNERAL DIRECTOR: IMPORTANT

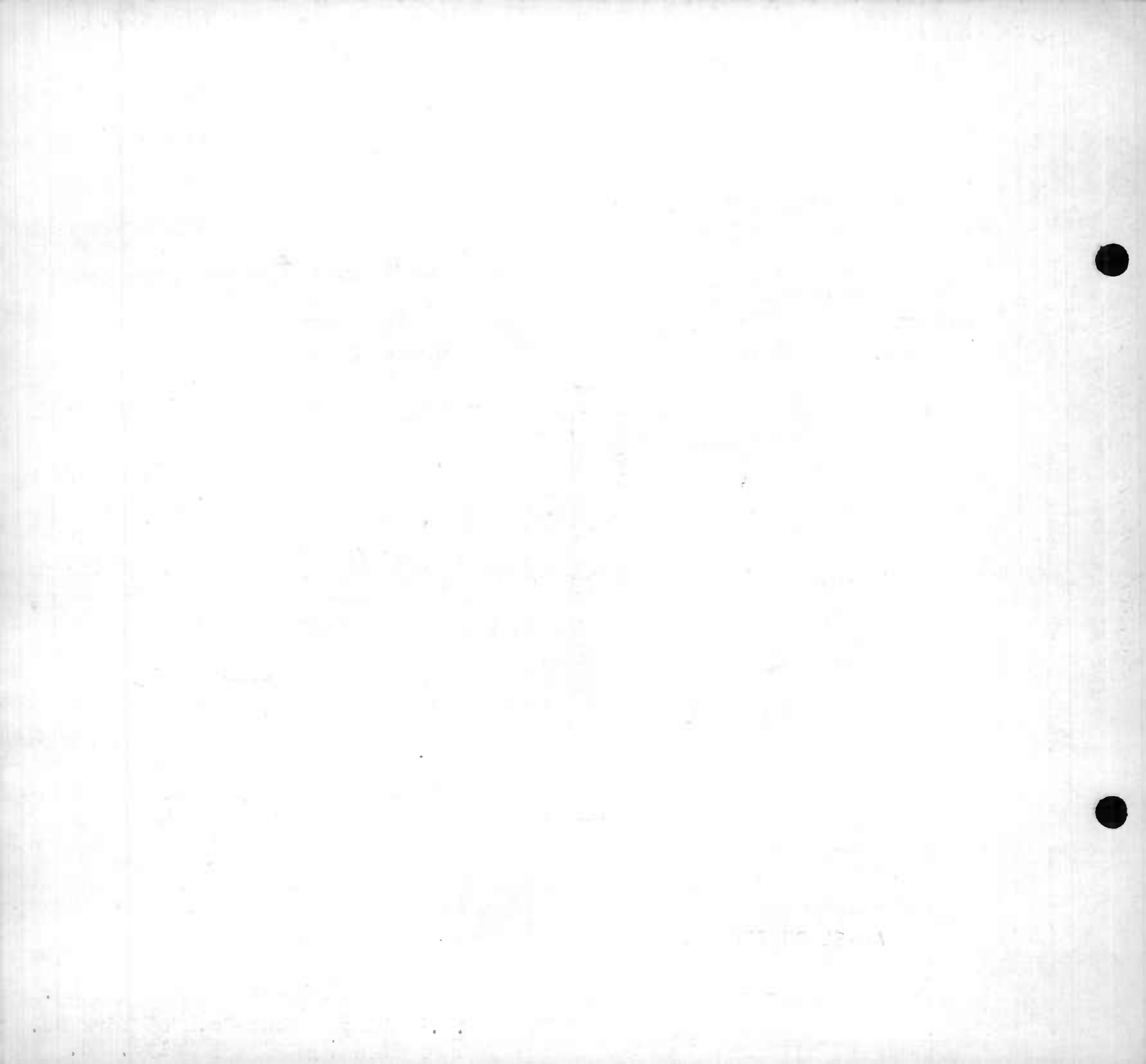
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |         |  |   | Registered No.   |   |
|---|---------|--|---|--|---|
| BIRTH NO.   |         | 65 3770  |   | 65 3770  |   |
| M.E. CASE NO.   |         |  |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  | 2. DATE AND HOUR OF DEATH   |  |   |
| GLADYS SELBY  |         |  | 4/7/65 1:50 A.M.  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)  |         |  | A. STATE<br>B. COUNTY   |  |   |
| LUTHERAN HOSPITAL   |         |  | MARYLAND 16-07  |  |   |
|   |         |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |   |
|   |         |  | BALTIMORE   |  |   |
|   |         |  | D. STREET ADDRESS (If rural, give location)   |  |   |
|   |         |  | 1227 ASHBURTON STREET   |  |   |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH  | 9. AGE (In years<br>lost birthday)                                       | If Under 1 Yr.<br>Months: Days: Hours: Min. |
| FEMALE  | NEGRO   | DIVORCED   | 7/22/21   | 43   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |   |
| Electronic worker   |         | AIRCRAFT   |   | North Carolina   |   |
| 13. FATHER'S NAME   |         |  | 12. CITIZEN OF WHAT COUNTRY?  |  |   |
| EMMONS, ALEXANDER   |         |  | USA   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)   |         |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                       |
| No  |         |  | 216-20-1547   |  | Ruth Purnell - 1909 BRADDISH AVE.           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  | CAUSE OF DEATH  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  |         |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |   |  |   |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
| 0   |         |  |   | NO   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
|   |         |  |   |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
|   |         |  |   |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 3/30 1965 to 4/7 1965, that (I) (we) last saw the deceased alive on 4/7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |   |  |   |
| 23A. SIGNATURE<br>Oscar Fernandini  |         |  |   | 23B. DATE SIGNED<br>4/7/65   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>OSCAR FERNANDINI  |         |  |   | 23D. ADDRESS<br>Lutheran   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |   | 24C. NAME OF CEMETERY or CREMATORY                                       |   |
| Burial  |         | 4-10-65  |   | Mt. Auburn   |   |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR ADDRESS  |   |
| APR 8 1965  |         | Robert E. Taylor   |   | MARSHALL W. JONES, JR. - 1735 HARFORD AVE.                               |   |



released on approval by the Medical Examiner  
FUNERAL DIRECTOR: IMPORTANT  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |           |  |  |  |   |
|--|-----------|--|--|--|---|
| BIRTH NO. 65 3771  |           | CITY OF BALTIMORE DEPARTMENT   |  | Registered No. 65 3771   |   |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) JANE L. PITTS  |           |  | 2. DATE AND HOUR OF DEATH April 5 1965 10:45 P.M.  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) UNION MEMORIAL HOSPITAL   |           |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY LUTHERVILLE BALTO. C. CITY OR TOWN (If outside city limits, write RURAL and give township) LUTHERVILLE 5300 D. STREET ADDRESS (If rural, give location) COLLEGE MANOR HOME |  |   |
| 5. SEX F   | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED | 8. DATE OF BIRTH 10/10/82  | 9. AGE (In years lost birthday) 82                                     | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE   |           | 10B. KIND OF BUSINESS OR INDUSTRY                                    |  | 11. BIRTHPLACE (State or foreign country) MARYLAND                     |   |
| 13. FATHER'S NAME CHARLES DICKINSON PITTS  |           |  | 14. MOTHER'S MAIDEN NAME MARIE LONDON ?  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No  |           | 16. SOCIAL SECURITY NO. 10-38-2965                                   |  | 17. INFORMANT JAMES PIPER III 2631 N. CHARLES ST.                      |   |
| 18. 350X+LE903.7 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. II |           |  | CAUSE OF DEATH Bronchopneumonia Fracture, Left hip Paralysis Agitans   |  | INTERVAL BETWEEN ONSET AND DEATH 5 days. 10 days. years.                                  |
| 19A. DATE OF OPERATION 3/3/65  |           |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Left hip fracture   |  | 20A. AUTOPSY? (Yes or No) Yes   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |           |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) King home   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) LUTHERVILLE, MD. |
| 21D. TIME OF INJURY (APPROX.) 3 25 65 PM   |           |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR? Got up from toilet & fell to floor April                       |
| 22. I certify that (I) (this hospital) attended the deceased from April 26 1965 to March 5 1965, that (I) (we) last saw the deceased alive on March 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |           |  |  |  |   |
| 23A. SIGNATURE Daniel Prieto   |           |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED 4-5-1965   |
| 23C. PHYSICIAN'S NAME (Type) DANIEL PRIETO   |           |  | 23D. ADDRESS Union Memorial Hosp.  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |           | 24B. DATE 4-7-65   | 24C. NAME OF CEMETERY or CREMATORY Greenmount  |  | 24D. LOCATION (City, town, or county) (State) Baltimore Md.                               |
| 25A. DATE REC'D BY HEALTH DEPT. APR 8 1965   |           | 25B. NAME OF REGISTRAR Robert E. Jenkins                             |  | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. Md. |   |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                     |   |                                    | BIRTH NO. 65 3772   |                              | REGISTERED NO. 65 3772   |  |
|---|---------------------|---|------------------------------------|---|------------------------------|--|--|
| <b>CERTIFICATE OF DEATH</b>   |                     |   |                                    | Registered No. 65 3772  |                              |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>IVOR JAMES</b>  |                     |   |                                    | 2. DATE AND HOUR OF DEATH<br><b>4-7-65</b> <b>4 P.M.</b>  |                              |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Union Memorial</b>  |                     |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Balto</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Towson</b> <b>53-00</b><br>D. STREET ADDRESS (If rural, give location)<br><b>West Road - W. J. Towson Nursing Home</b> |                              |  |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                                  | 8. DATE OF BIRTH<br><b>1/22/76</b> | 9. AGE (In years last birthday)<br><b>88</b>  | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired - CUSTODIAN</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>CHRIST CHURCH</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Wales, England</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Richard H. James</b>  |                     |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Sarah ?</b>  |                              |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>212-10-7186</b>   |                                    | 17. INFORMANT<br><b>Son - Richard James</b>   |                              | ADDRESS #12<br><b>6744 Glen Kirk Rd</b>  |  |
| 18. <b>420.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                     |   |                                    | (A) <b>Cerebral Vascular Accident</b><br>DUE TO<br><b>2 WKS.</b>  |                              | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                              |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?  |                              |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/31/1965</b> to <b>4/7/1965</b> , that (I) (we) last saw the deceased alive on <b>4/7/1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>not</del> view the body after death.  |                     |   |                                    |   |                              |  |  |
| 23A. SIGNATURE<br><b>Miriam R. Cohen</b><br>M.O. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                     |   |                                    | 23B. DATE SIGNED<br><b>4-7-65</b>   |                              |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Miriam R. Cohen M.D.</b>   |                     |   |                                    | 23D. ADDRESS<br><b>Union Memorial Hospital</b>  |                              |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>4/9/1965</b>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Moreland Memorial Park</b>   |                              | 24D. LOCATION (City, town, or county) (State)<br><b>Parkville, Balto. Co., Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |                     | 25B. NAME OF REGISTRAR<br><b>R. E. Stahler</b>  |                                    | 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co.</b><br>ADDRESS<br><b>1905 York Rd. Balto. 12, Md.</b>  |                              |  |  |

Handwritten text, likely a letter or document, with several lines of cursive script. The text is mostly illegible due to fading and bleed-through from the reverse side.

Handwritten text at the bottom left, possibly a signature or date.

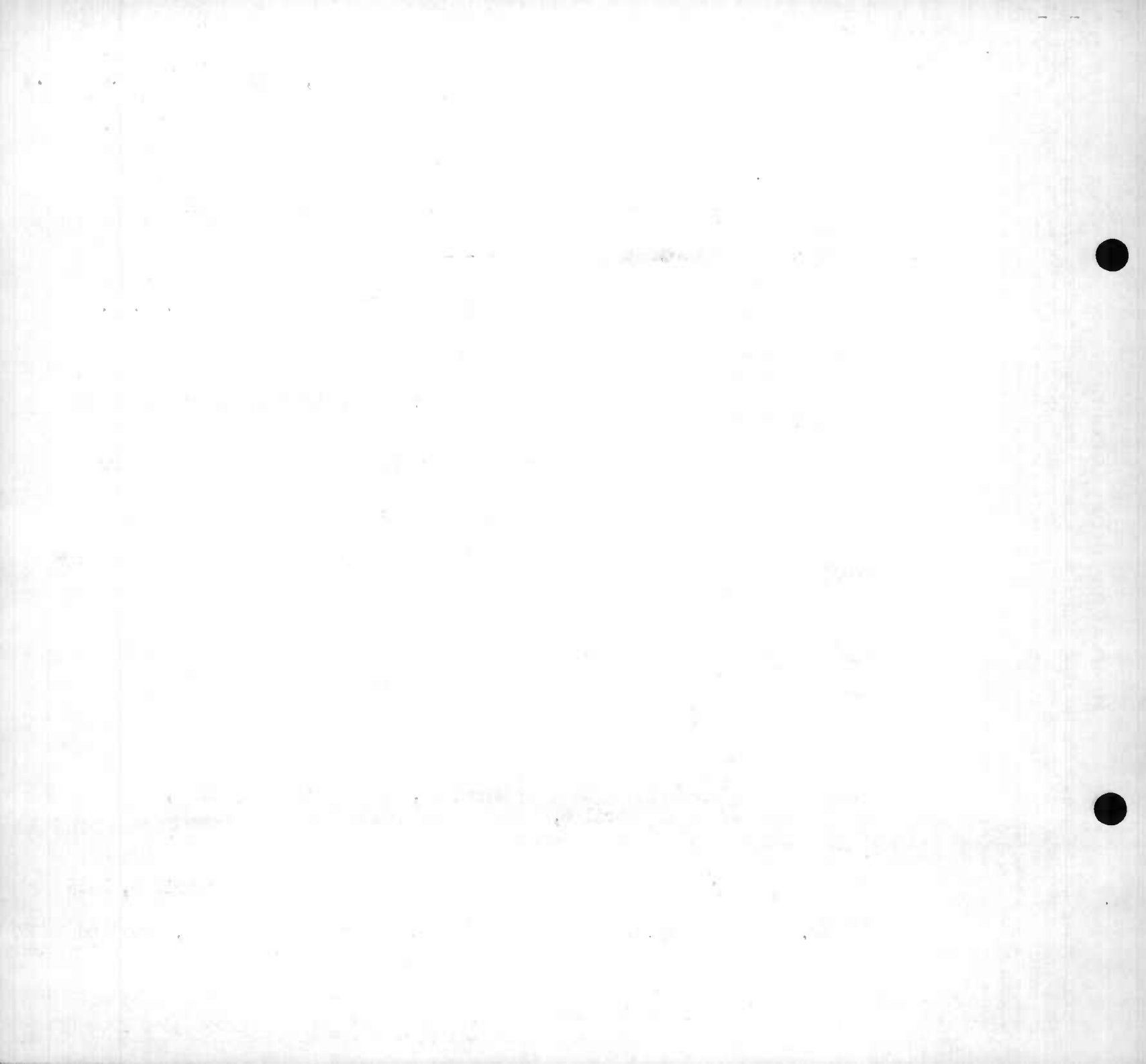
Handwritten text in the lower middle section, possibly a date or a short note.

Handwritten text at the bottom right, possibly a signature or a closing phrase.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |  |   |  |
|--|-------------------------|---|--|---|--|
| BIRTH NO. <b>65 3773</b>   |                         | <b>BALTIMORE CITY HEALTH DEPARTMENT</b>   |  | Registered No. <b>65 3773</b>   |  |
| <b>CERTIFICATE OF DEATH</b>  |                         |   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Harold Cobb</b>  |                         | 2. DATE AND HOUR OF DEATH<br><b>April 6, 1965 6:45 P.M.</b>   |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals<br/>4940 Eastern Avenue<br/>Baltimore, Maryland 21224</b>   |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>16-06</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1006 Franklinton Road 21216</b> |  |   |  |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>Negro</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Never married</b>  |  | 8. DATE OF BIRTH<br><b>11-3-1911</b>  | 9. AGE (In years lost birthday)<br><b>53</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                         | 13. FATHER'S NAME<br><b>George Cobb</b>   |  |   |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Morethera</b>   |                         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  |
| 16. SOCIAL SECURITY NO.  |                         | 17. INFORMANT ADDRESS<br><b>RECORDS: BCH 4940 Eastern Avenue 21224</b>  |  |   |  |
| 18. CAUSE OF DEATH<br><b>42011 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                         | (A) <b>Arteriosclerotic Heart Disease</b><br>DUE TO   |  | 2 Years   |  |
|  |                         | (B) <b>Pulmonary Emboli</b><br>DUE TO   |  | 2 Days  |  |
|  |                         | (C) <b>Myocardial Infarction</b>  |  | 2 Years ago   |  |
| MEDICAL CERTIFICATION  |                         |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>March 30, 1965</b> to <b>April 6, 1965</b> , that (I) (we) lost saw the deceased alive on <b>April 6, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |  |   |  |
| 23A. SIGNATURE<br><b>Dr. Charles Carpenter</b>   |                         |   |  | 23B. DATE SIGNED<br><b>April 6, 1965</b>                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Charles Carpenter</b>   |                         |   |  | 23D. ADDRESS<br><b>4940 Eastern Avenue Baltimore, Maryland 21224</b>        |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4-11-65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Church Lane</b>                    |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Goldsboro, N. C.</b>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |  |   |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Stage 4, Room 1348 N. Collins St</b>  |  |   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3774   |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |   | CERTIFICATE OF DEATH   |  | Registered No. 65 3774                        |  |
|---|-------------------------|---|--|---|---|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ANNA B. BORIG</b>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>April 7, 1965 9<sup>00</sup>/A M.</b>   |   |  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital at institution, give street address or location)<br><b>4004 ERDMAN AVENUE</b>  |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>26-03</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore 13</b><br>D. STREET ADDRESS (If rural, give location) <b>4004 Erdman Ave</b> |   |  |  |   |  |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widow</b>                                  | 8. DATE OF BIRTH<br><b>1889 100.6.1889</b> |   | 9. AGE (In years last birthday)<br><b>75</b>                            |  | If Under 1 Yr. Months: Days: Hours: Min.                       |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housekeeper</b>   |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY          |   |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>           |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>Frederick Blahnik</b> NOVAK   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Barbara <del>Blahnik</del> VANCURA</b>   |   |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         |   | 16. SOCIAL SECURITY NO.<br><b>-----</b>    |   | 17. INFORMANT<br><b>Clara Oppenhausen</b> ADDRESS<br><b>4004 Erdman</b> |  |  |   |  |
| 18. <b>4-20-11 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis</b><br>(A) DUE TO  |                         |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>22 days</b>  |   |  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Arterio sclerotic</b><br>(B) DUE TO<br><b>Cardiovascular Disease</b><br>(C)  |                         |   |  | <b>10 years</b>   |   |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |  |   |   |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>March 15 1965</b> to <b>April 7 1965</b> .<br>that (I) (we) last saw the deceased alive on <b>April 7 1965</b> and that in (my) (our) opinion death occurred on the date<br>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |  |   |   |  |  |   |  |
| 23A. SIGNATURE<br><b>B. M. M. M. M. M.</b> M.D.   |                         |   |  | 23B. DATE SIGNED<br><b>April 7, 1965</b>  |   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>BENIGNO M. OTEY ZA</b> M.D. |   |  |
| 23D. ADDRESS<br><b>5506-A RECREST Rd., BALT., Md. 21206</b>   |                         |   |  |   |   |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>4/10/65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>BALTIMORE CEMETERY</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MD.</b> |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Stanley</b>  |  | 25C. FUNERAL DIRECTOR<br><b>LEONARD J. RUCK, INC., BALTO., MD. 21214</b>  |   |  |  |   |  |

RECEIVED  
APR 17 1971  
MAY 17 1971  
APR 17 1971

RECEIVED M. STEYER

*[Signature]*

65 3775

BALTIMORE CITY HEALTH DEPARTMENT

65 3775

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED  
(Type or Print)

RICHARD T. MINDERLEIN

2. DATE AND HOUR PRONOUNCED DEAD

April 7, 1965

4:20 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2634 Wycliffe Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

FEB. 3, 1945

9. AGE (in years  
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CLERK

10B. KIND OF BUSINESS OR INDUSTRY

B &amp; O R.R.

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

PHILIP G. MINDERLEIN

14. MOTHER'S MAIDEN NAME

IDA C. BROMWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

215440955

17. INFORMANT

PHILIP G. MINDERLEIN

ADDRESS

SAME

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple traumatic injuries  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

Street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Taylor Avenue east of Loch Raven Blvd.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 7 65 2:03a

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Passenger in auto fixed object accident

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-7-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4/10/65

23C. NAME of CEMETERY or CREMATORY

NEW CATHEDRAL CEMETERY

23D. LOCATION (City, town, or county)

BALTIMORE, MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 8

1965

24B. NAME OF REGISTRAR

Robert E. Farkas, M.D.

24C. FUNERAL DIRECTOR

LEONARD J. RUCK, INC., BALTO., MD. 21214

ADDRESS



VALLEY BOULE

WATER FRONT

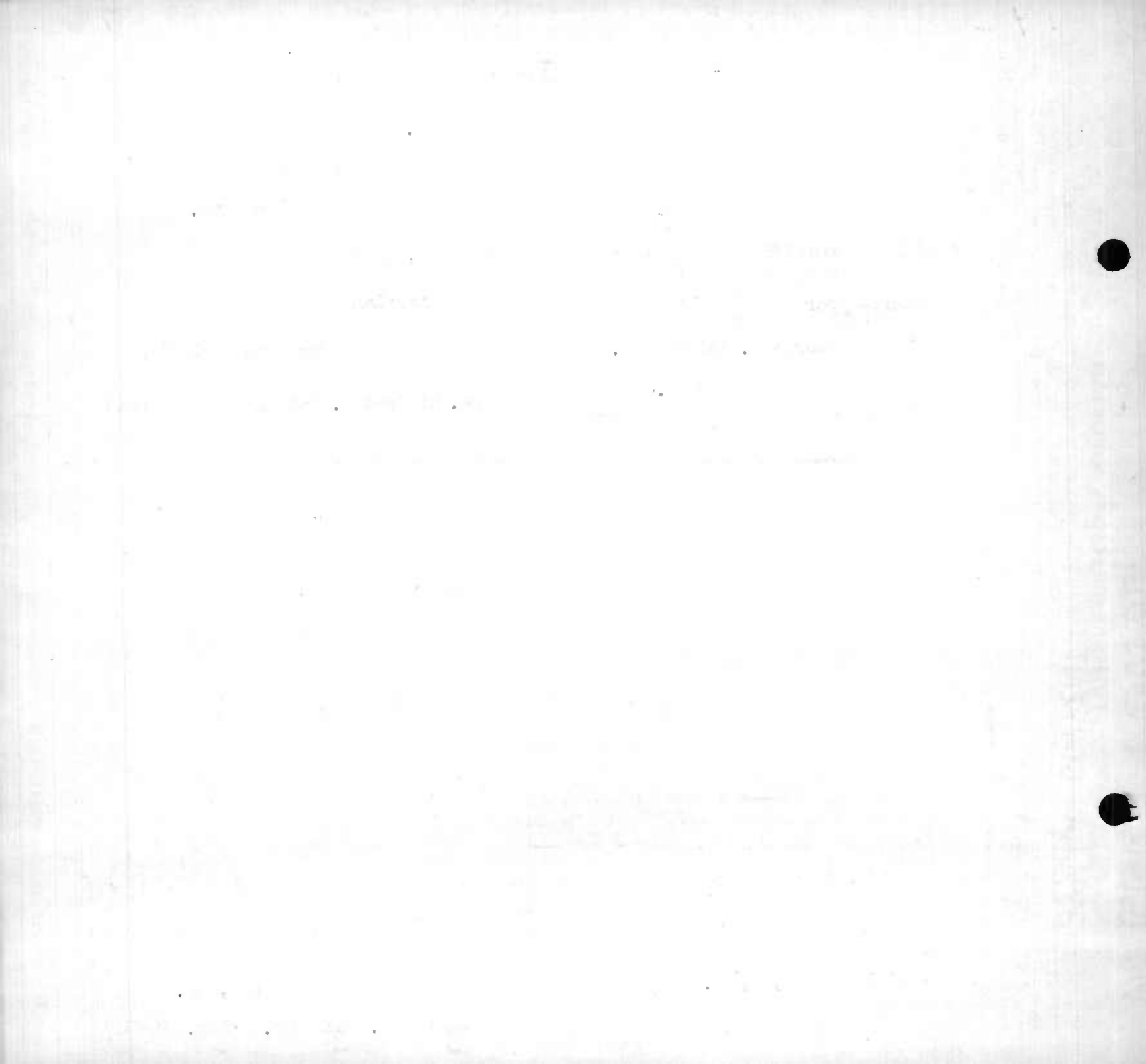
Proctor



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

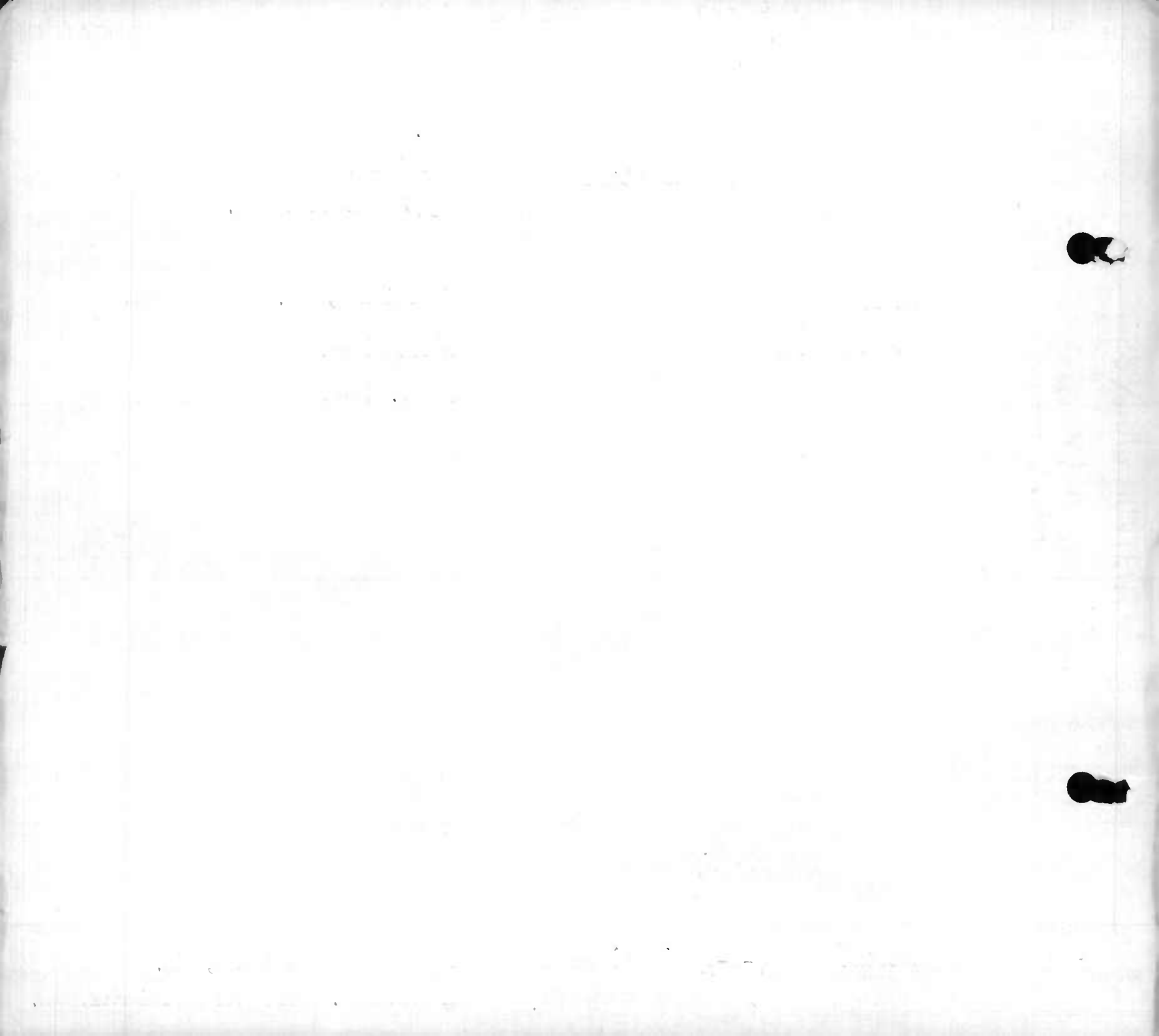
| BALTIMORE CITY HEALTH DEPARTMENT   |                  |  |  | Registered No. 65 3776   |  |
|--|------------------|--|--|--|--|
| BIRTH NO. 65 3776  |                  | CERTIFICATE OF DEATH   |  |  |  |
| M.E. CASE NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) GEORGE F. LEIPOLD, Jr.  |  | 2. DATE AND HOUR OF DEATH<br>4/7/65 13:07 A M.                           |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>UNION MEMORIAL HOSPITAL   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. 8. COUNTY 26-02<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore #6<br>D. STREET ADDRESS (If rural, give location) 4804 Bowland Ave. |  |  |  |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married  | 8. DATE OF BIRTH<br>March 18, 1901             | 9. AGE (In years last birthday)<br>64                                    | If Under 1 Yr. Months Days Hours Min.<br>If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Stereo-Typer  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    | 12. CITIZEN OF WHAT COUNTRY?<br>USA                            |
| 13. FATHER'S NAME<br>George F. Leipold Sr.   |                  |  | 14. MOTHER'S MAIDEN NAME<br>Caroline Christian |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Mildred I. Leipold                                 |  |
|  |                  |  |  | ADDRESS<br>(Same)  |  |
| 18. I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) DUE TO<br>Acute Myocardial Infarction<br>(B) DUE TO<br>Arteriosclerotic Heart Disease<br>(C) _____   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 Hour<br>Unknown                    |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |  |  |  |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1950 to 4/7/65, that (I) (we) last saw the deceased alive on 4/7/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |  |  |  |  |
| 23A. SIGNATURE<br>Martin T. Singewald  |                  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |  | 23B. DATE SIGNED<br>4/7/65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>MARTIN T. SINGEWALD  |                  | 23D. ADDRESS<br>11 E. Chase St Baltimore 2 Md.   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>4/10/65   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Parkwood Cemetery                  |  |
|  |                  |  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Md.          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor   |  | 25C. FUNERAL DIRECTOR<br>Leonard J. Ruck Inc. Balto. Md/21214            |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3777   |                     |  |                                   | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3777   |  |
|---|---------------------|--|-----------------------------------|--|--|--|--|
| M.E. CASE NO.   |                     |  |                                   | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BABY GIRL NUTH</b>  |                     |  |                                   | 2. DATE AND HOUR OF DEATH<br><b>4-7-65</b>   |  | 1:40 A.M.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Mercy Hospital</b>  |                     |  |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>2601</b>   |  |  |  |
|   |                     |  |                                   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 6</b>  |  |  |  |
|   |                     |  |                                   | D. STREET ADDRESS (If rural, give location)<br><b>5913 Marluth Ave.</b>  |  |  |  |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>SINGLE</b>                              | 8. DATE OF BIRTH<br><b>4-6-65</b> | 9. AGE (In years last birthday)  | If Under 1 Yr. Months: Days  | If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>None</b>  |                     |  | 10B. KIND OF BUSINESS OR INDUSTRY |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b> |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |
| 13. FATHER'S NAME<br><b>Robert Nuth</b>   |                     |  |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Beverly Towers</b>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                     | 16. SOCIAL SECURITY NO.  |                                   | 17. INFORMANT<br><b>Lee T. Towers</b>  |  | ADDRESS<br><b>same</b>   |  |
| 18. <b>776X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Immaturity</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                     |  |                                   | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C)  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Life</b>                        |  |
| 19A. DATE OF OPERATION  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                   | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/6 11:55 am 1965</b> to <b>4/7 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (and) (did not) view the body after death.  |                     |  |                                   |  |  |  |  |
| 23A. SIGNATURE<br><b>Willard E. Staudt</b>  |                     |  |                                   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><b>4/7/65</b>                                      |  |
| 23C. PHYSICIAN'S NAME (Type)  |                     |  |                                   | 23D. ADDRESS<br>M.D.   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                     | 24B. DATE<br><b>4-8-65</b>   |                                   | 24C. NAME of CEMETERY or CREMATORY<br><b>Parkwood Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |                                   | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc</b>  |  | ADDRESS<br><b>Baltimore, Md.</b>                                       |  |



R 152

65 3778

BALTIMORE CITY HEALTH DEPARTMENT

65 3778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HATTIE ROBINSON

2. DATE AND HOUR PRONOUNCED DEAD

4-4-65 2:15 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL - DOA

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

422 N. Pine Street 21201

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

Oct. 26, 1912

9. AGE (In years  
last birthday)

52

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laundress

10B. KIND OF BUSINESS OR INDUSTRY

Hospital

11. BIRTHPLACE (State or foreign country)

Littleton N.C.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Sam Johnson

14. MOTHER'S MAIDEN NAME

Lucinda Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Helen Thorne 302 Lynhurst St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

and malnutrition

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT  
WORK

NOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED  
4-5-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

April 5, 1965 Mt. Auburn Cem.

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION (City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 8 1965

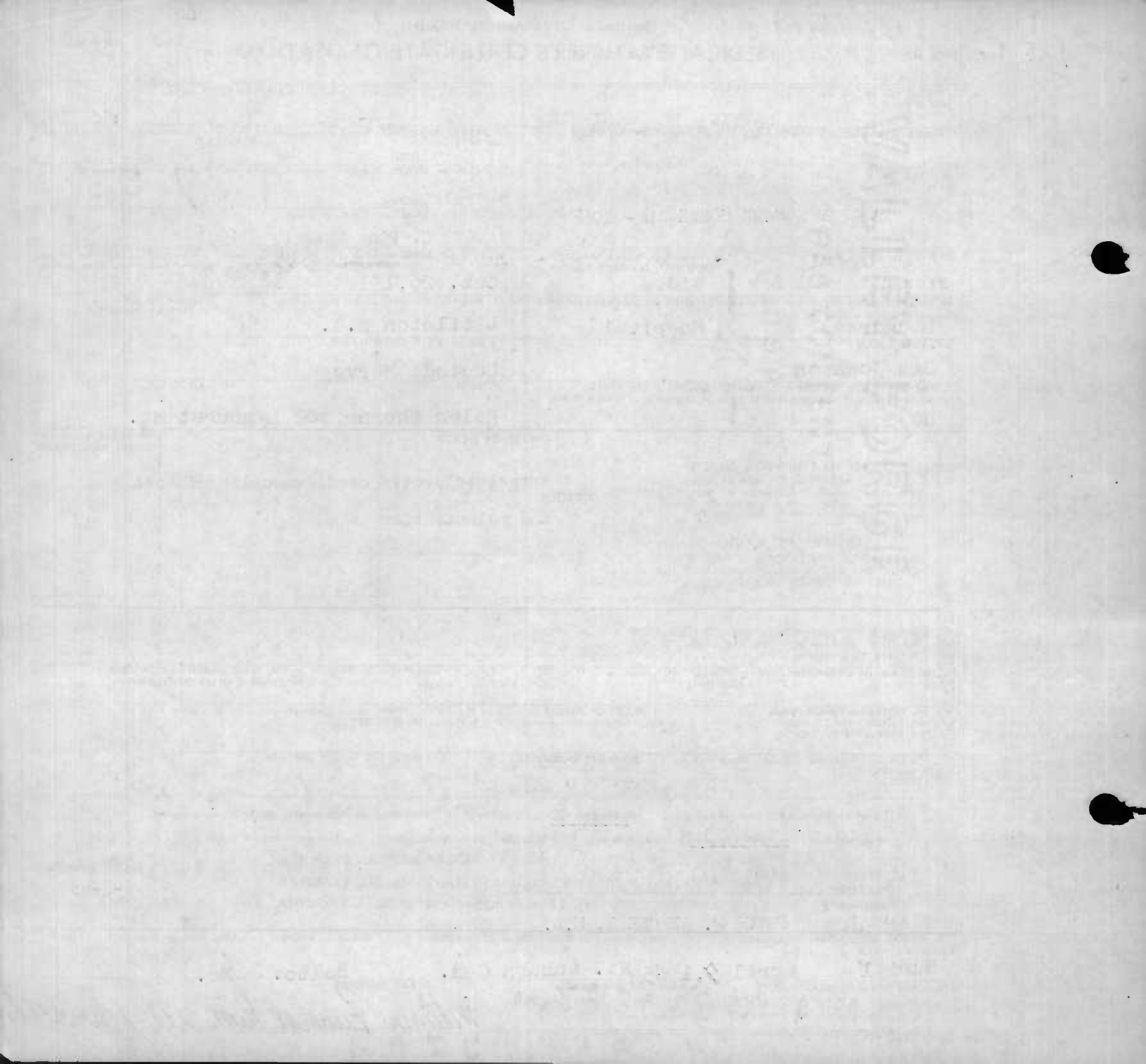
24B. NAME OF REGISTRAR

Robert E. Farber, M.D.

24C. FUNERAL DIRECTOR

Williams Funeral Home 319 N. Lombard St.

ADDRESS



1  
2000

65 3779

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 3779

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIAM F. LEE

2. DATE AND HOUR PRONOUNCED DEAD

April 5, 1965

10:25 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

FRANKLIN SQUARE HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

17 N. Bruce Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

March 2, 1909

9. AGE (In years  
lost birthday)

56

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

House  
Meat packing

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

William Lee

14. MOTHER'S MAIDEN NAME

Bessie Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

16. SOCIAL  
SECURITY NO.

216-01-7191

17. INFORMANT

ADDRESS

William A. Lee 17 N. Bruce St.

18.

443X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

April 9, 1965 Mt. Auburn

23C. NAME OF CEMETERY or CREMATORY

23D. LOCATION

(City, town, or county)

(State)

Balto. Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

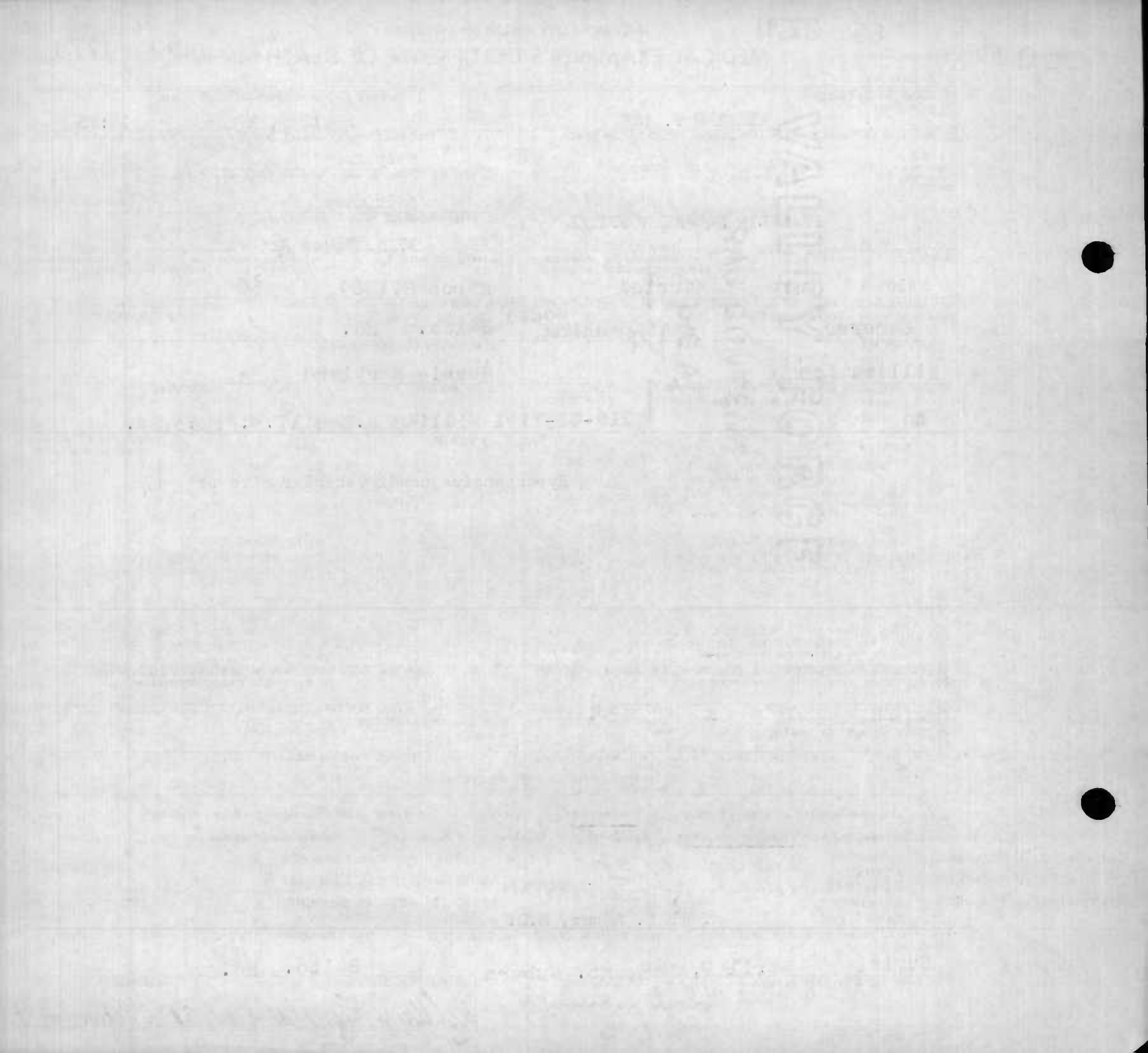
24C. FUNERAL DIRECTOR

ADDRESS

APR 8 1965 Robert E. Farley M.D.

Williams Funeral Home 329 N. Schroeder St.







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

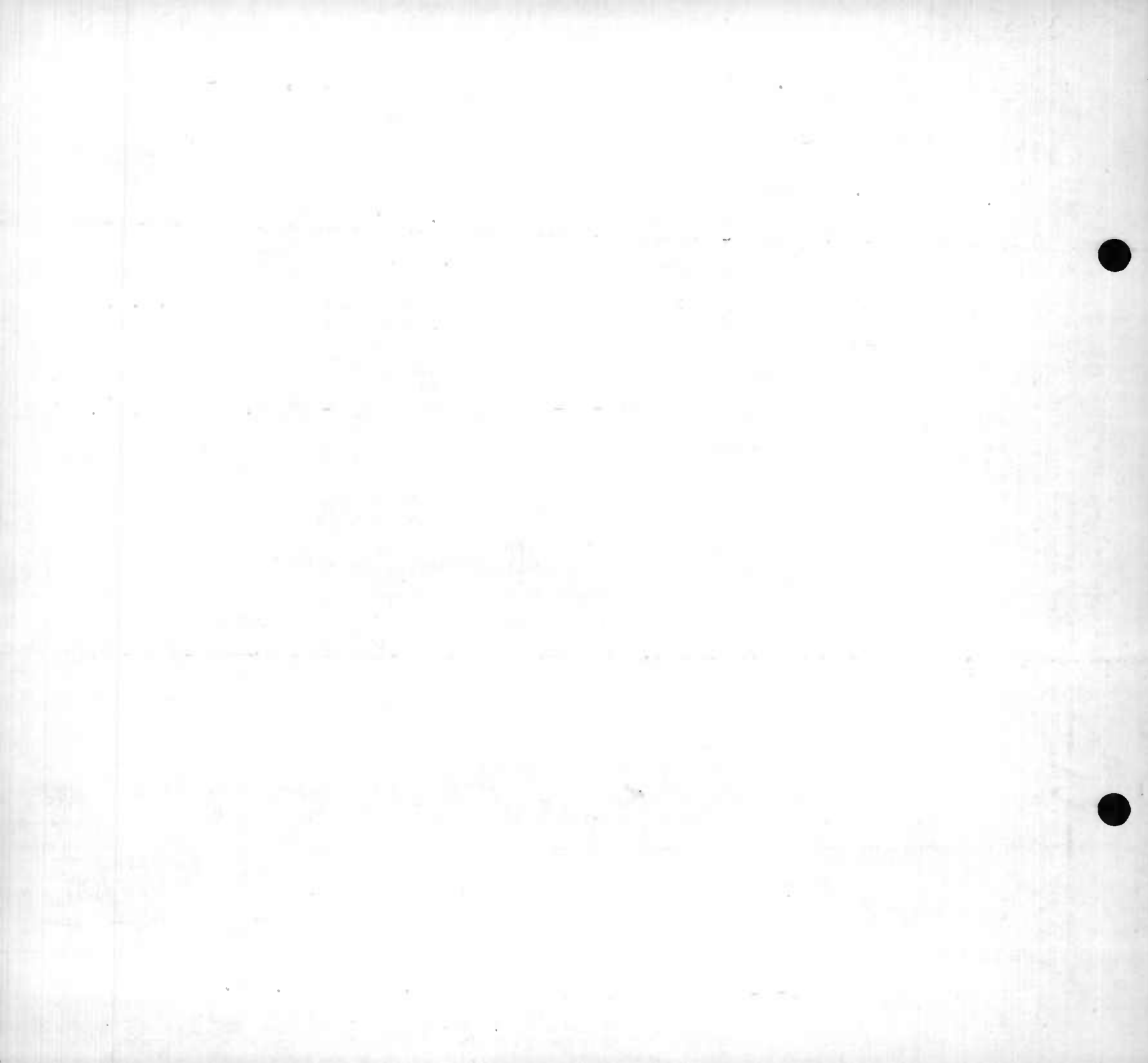
| BIRTH NO. 65 3780  |                         |   |   | BALTIMORE CITY HEALTH DEPARTMENT  |                            | Registered No. 65 3780  |  |
|--|-------------------------|---|---|---|----------------------------|---|--|
| M.E. CASE NO.  |                         |   |   | CERTIFICATE OF DEATH  |                            |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MATTHEWS, JAMES J. Sr.</b>   |                         |   |   | 2. DATE AND HOUR OF DEATH<br><b>April 4, 1965 16:45 P.</b>  |                            |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Joseph Hospital</b>  |                         |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>2605</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 24</b><br>D. STREET ADDRESS (If rural, give location)<br><b>6311 Fait Avenue</b> |                            |   |  |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>                                | 8. DATE OF BIRTH<br><b>9/9/04</b>                   | 9. AGE (In years last birthday)<br><b>60</b>  | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Crane Operator</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Bethlehem Steel</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>James T. Matthews</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Feeney</b> |   |                            |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>213-07-6121</b>   |   | 17. INFORMANT<br><b>Anna Matthews 6311 Fait Ave. Balto. 24, Md.</b>   |                            |   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Recent posterior myocardial infarct</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Large chronic pyloric ulcer</b> |                         |   |   | INTERVAL BETWEEN ONSET AND DEATH  |                            |   |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |   |   |                            |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                            |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |                            |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/31</b> 19 <b>65</b> to <b>4/4</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>4/4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |   |   |                            |   |  |
| 23A. SIGNATURE<br><b>William B. VandeGrift</b>   |                         |   |   | 23B. DATE SIGNED<br><b>April 5, 1965</b>  |                            | 23C. PHYSICIAN'S NAME (Type)<br><b>William B. VandeGrift</b>                              |  |
| 23D. ADDRESS<br><b>1400 N. Caroline St., Baltimore, Md. 21213</b>  |                         |   |   | 23E. FUNERAL DIRECTOR<br><b>Charles J. Zile</b>   |                            |   |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4-8-65</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>  |                            | 24D. LOCATION (City, town, or county) (State)<br><b>7225 Eastern Blvd. Balto. 24, Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 8 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>6224 Eastern Avenue Balto. Md. 21224</b>  |                            |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

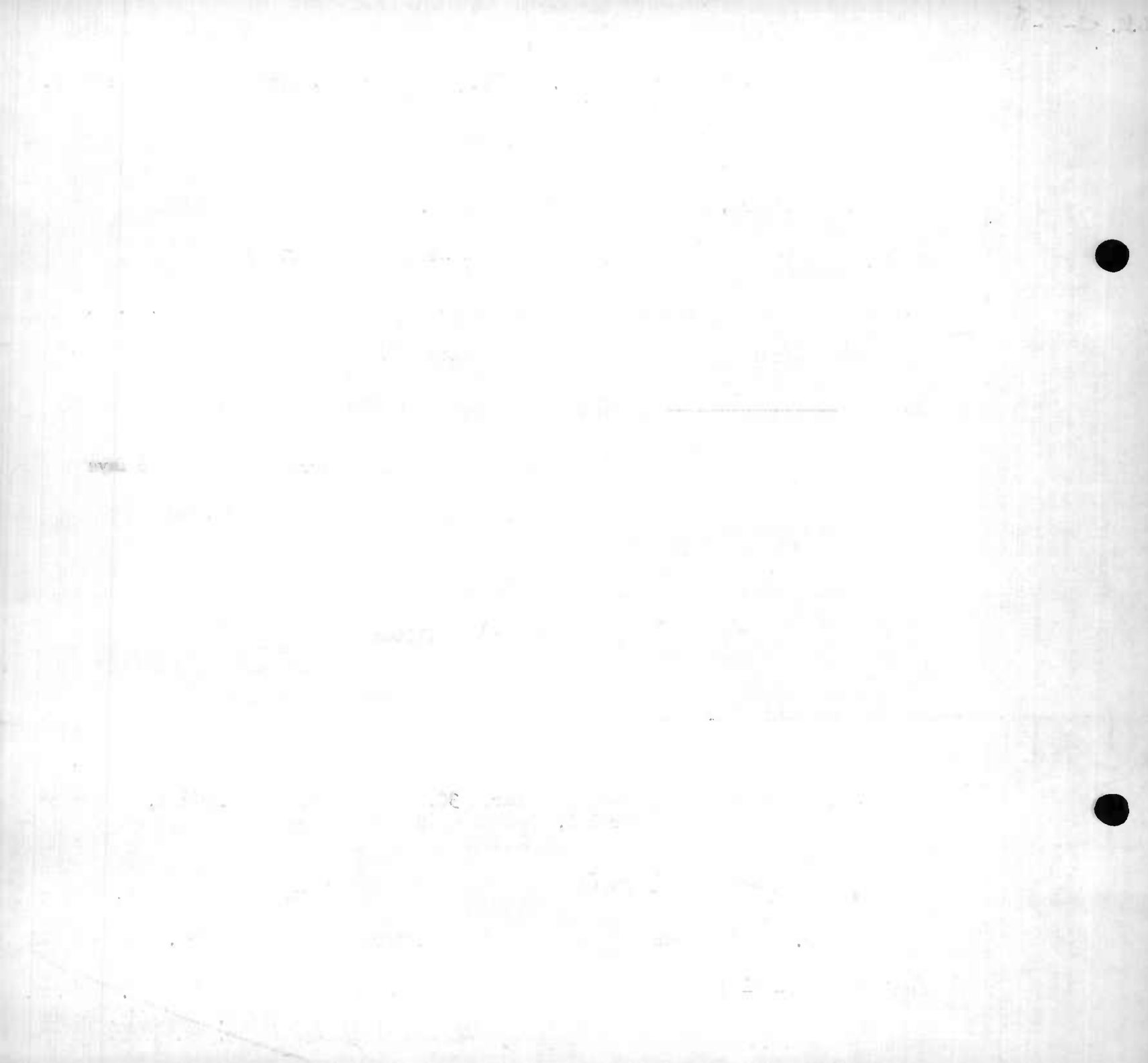
|  |                  |   |   |  |   |
|--|------------------|---|---|--|---|
| BIRTH NO. 65 3781  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |   | Registered No. 65 3781   |   |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print) Otto G. Stephan  |                  |   | 2. DATE AND HOUR OF DEATH<br>April 5, 1965 - 10:55 A.M.   |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>35 S. Decker Avenue   |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY 102<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>35 S. Decker Avenue |  |   |
| 5. SEX<br>Male   | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Divorced                                      | 8. DATE OF BIRTH<br>Nov. 22, 1892   | 9. AGE (In years last birthday)<br>72                                    | If Under 1 Yr. Months: Days: Hours: Min.<br>If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Butcher Acme Stores   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br>Pennsylvania                |   |
| 13. FATHER'S NAME<br>Unknown   |                  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.<br>212-03-7126  |   | 17. INFORMANT ADDRESS<br>Clara Groth - 35 S. Decker Ave.                 |   |
| 18. <u>420.1</u> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   | (A) DUE TO<br>coronary occlusion<br>(B) DUE TO<br>hypertensive CVD<br>(C) DUE TO<br>old coronary occlusion  |  | INTERVAL BETWEEN ONSET AND DEATH<br>10 min.<br>?<br>?             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |   | congestive heart failure chronic  |  |   |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from Feb 23 1965 to April 5 1965, that (I) (we) last saw the deceased alive on April 5 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |   |   |  |   |
| 23A. SIGNATURE<br>Benton V. Lock M.D.  |                  |   | 23B. DATE SIGNED<br>4/6/65  |  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Benton V. Lock M.D.  |                  |   | 23D. ADDRESS<br>2936 E. Baltimore St. #24   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>5-8-65   |   | 24C. NAME OF CEMETERY or CREMATORY<br>Gardens of Faith Cem.              |   |
| 24D. LOCATION (City, town, or county)<br>Balto. Md.  |                  |   |   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 8 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor M.D.   |   | 25C. FUNERAL DIRECTOR<br>John C. Miller Inc. - 6415 Belair Rd.           |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

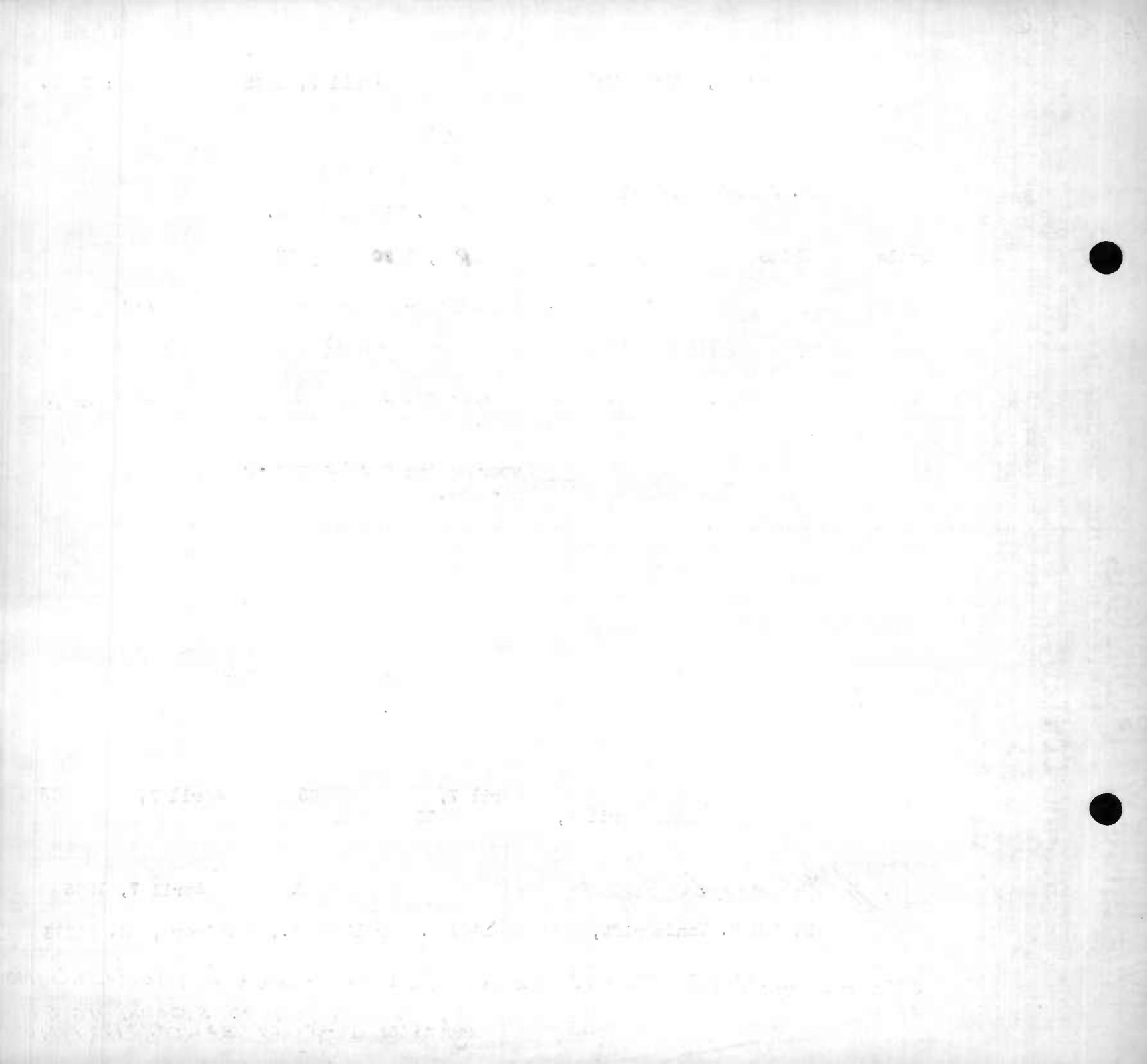
| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |   | Certificate of Death  |  | Registered No. <span style="font-size: 1.2em;">65 3782</span>   |  |
|--|--|---|---|---|--|---|--|
| BIRTH NO. <span style="font-size: 1.2em;">65 3782</span>   |  | M.E. CASE NO.   |   | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |
|  |  |   |   | <span style="font-size: 1.2em;">Mary Cushner (Mary A. Cushner)</span>                 |  | <span style="font-size: 1.2em;">April 4, 1965</span>   <span style="font-size: 1.2em;">10:30 P. M.</span> |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION   |  | (If not in hospital or institution, give street address or location)  |   | A. STATE  |  | B. COUNTY   |  |
| <span style="font-size: 1.2em;">Baltimore, City Hospitals</span><br><span style="font-size: 1.2em;">4940 Eastern Avenue</span><br><span style="font-size: 1.2em;">Baltimore, Maryland #21224</span>  |  | <span style="font-size: 1.2em;">Maryland</span><br><span style="font-size: 1.2em;">Baltimore</span><br><span style="font-size: 1.2em;">637 S. Grundy Street #21224</span> |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |   |  |
|  |  |   |   | D. STREET ADDRESS (If rural, give location)   |  |   |  |
|  |  |   |   |   |  |   |  |
| 5. SEX   | 6. RACE                                      | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)  | 8. DATE OF BIRTH                              | 9. AGE (In years lost birthday)   | 10. CITIZEN OF WHAT COUNTRY?   |   |  |
| <span style="font-size: 1.2em;">Female</span>  | <span style="font-size: 1.2em;">White</span> | <span style="font-size: 1.2em;">Widowed</span>  | <span style="font-size: 1.2em;">2-2-90</span> | <span style="font-size: 1.2em;">74</span>   | <div style="display: flex; justify-content: space-between;"> <span>If Under 1 Yr. Months</span> <span>If Under 24 Hrs. Days</span> <span>If Under 24 Hrs. Hours</span> <span>If Under 24 Hrs. Min.</span> </div> |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| <span style="font-size: 1.2em;">Retired</span>   |  | <span style="font-size: 1.2em;">Housework</span>  |   | <span style="font-size: 1.2em;">Pennsylvania</span>                                   |  | <span style="font-size: 1.2em;">U. S. A.</span>   |  |
| 13. FATHER'S NAME  |  |   |   | 14. MOTHER'S MAIDEN NAME  |  |   |  |
| <span style="font-size: 1.2em;">John Adams</span>  |  |   |   | <span style="font-size: 1.2em;">Mary ?</span>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT ADDRESS   |  |   |  |
| <span style="font-size: 1.2em;">No</span>  |  | <span style="font-size: 1.2em;">None</span>   |   | <span style="font-size: 1.2em;">RECORDS: BCH: 4940 Eastern Avenue #21224</span>       |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |   |   | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |   |   | (A) <span style="font-size: 1.2em;">Cerebral Vascular Hemorrhage</span>               |  | <span style="font-size: 1.2em;">6 Days</span>   |  |
|  |  |   |   | (B) <span style="font-size: 1.2em;">Hypertensive Cardio Vascular Disease</span>       |  |   |  |
|  |  |   |   | (C)   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |   | <span style="font-size: 1.2em;">Diabetes Mellitus</span>                              |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                      |  |
| <span style="font-size: 1.2em;">0</span>   |  |   |   | <span style="font-size: 1.2em;">No</span>   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |   |  |
|  |  |   |   |   |  |   |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED  |   | 21F. HOW DID INJURY OCCUR?  |  |   |  |
|  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">March 30,</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">April 4,</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 4,</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |   |   |  |   |  |
| 23A. SIGNATURE   |  |   |   | 23B. DATE SIGNED  |  |   |  |
| <span style="font-size: 1.2em;">Philip Zieve</span>  |  |   |   | <span style="font-size: 1.2em;">April 4, 1965</span>                                  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS  |   |   |  |   |  |
| <span style="font-size: 1.2em;">Dr. Philip Zieve</span>  |  | <span style="font-size: 1.2em;">4940 Eastern Avenue Baltimore, Maryland #24</span>  |   |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE   |   | 24C. NAME of CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)   |  |
| <span style="font-size: 1.2em;">Burial</span>  |  | <span style="font-size: 1.2em;">4-7-65</span>   |   | <span style="font-size: 1.2em;">New Cathedral Cemetery</span>                         |  | <span style="font-size: 1.2em;">4300 Old Frederick Ave. Balto. Md.</span>                                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR  |   | 25C. FUNERAL DIRECTOR   |  | ADDRESS   |  |
| <span style="font-size: 1.2em;">APR 8 1965</span>  |  | <span style="font-size: 1.2em;">Robert E. Farley, M.D.</span>   |   | <span style="font-size: 1.2em;">Charles S. Seiler</span>                              |  | <span style="font-size: 1.2em;">901 S. Conkling Street Balto. Md. 21224</span>                            |  |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                         |  |  |  |  |  |   |  |  |                                  |
|--|-------------------------|--|--|--|--|--|---|--|--|----------------------------------|
| BIRTH NO. 65 3783  |                         |  |  |  | CERTIFICATE OF DEATH   |  |   |  |  |                                  |
| Registered No. 65 3783   |                         |  |  |  |  |  |   |  |  |                                  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Anderson, Elizabeth</b>  |                         |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>April 7, 1965</b>   <b>12:55 P. M.</b>   |  |   |  |  |                                  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Joseph Hospital</b>  |                         |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>26-10</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 21205</b><br>D. STREET ADDRESS (If rural, give location)<br><b>518 N. Highland Ave.</b> |  |   |  |  |                                  |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>Mar. 1, 1890</b>                | 9. AGE (In years last birthday)<br><b>85</b>                             | If Under 1 Yr. Months: Days: Hours: Min.   |  | If Under 24 Hrs. Min.                           |  |  |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED</b>  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>HOUSE WORK</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |  |  |                                  |
| 13. FATHER'S NAME<br><b>MICHAEL WINKELMAN</b>  |                         |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH MEYERS</b>  |  |   |  |  |                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         |  | 16. SOCIAL SECURITY NO.<br><b>NONE</b>                 |  | 17. INFORMANT<br><b>MRS. ELLA THOMS</b>  |  | ADDRESS<br><b>SAME</b>                          |  |  |                                  |
| 18. <b>443X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Hypertensive cardiovascular disease.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                         |  |  |  | CAUSE OF DEATH<br>(A) <b>Hypertensive cardiovascular disease.</b><br>(B) DUE TO<br>(C)   |  |   |  |  | INTERVAL BETWEEN ONSET AND DEATH |
| 19A. DATE OF OPERATION<br><b>2</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>           |   |  |  |                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |   |  |  |                                  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |   |  |  |                                  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 7, 1965</b> to <b>April 7, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 7, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |  |  |  |  |  |   |  |  |                                  |
| 23A. SIGNATURE<br><b>William B. VandeGrift</b> M.D.  |                         |  |  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  |   | 23B. DATE SIGNED<br><b>April 7, 1965</b> |  |                                  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>William B. VandeGrift</b> M.D.  |                         |  |  |  | 23D. ADDRESS<br><b>1400 N. Caroline St., Baltimore, Md. 21213</b>  |  |   |  |  |                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>4-10-65</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>SACRED HEART CEM</b>            |  | 24D. LOCATION (City, town, or county) (State)<br><b>7401 GERMAN HILL RD. BALTO. CO., MD.</b> |   |  |  |                                  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Farkner</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Charles S. Geiler</b>                        |  | ADDRESS<br><b>901 S. CONKLING ST. BALTO., MD.</b>  |   |  |  |                                  |

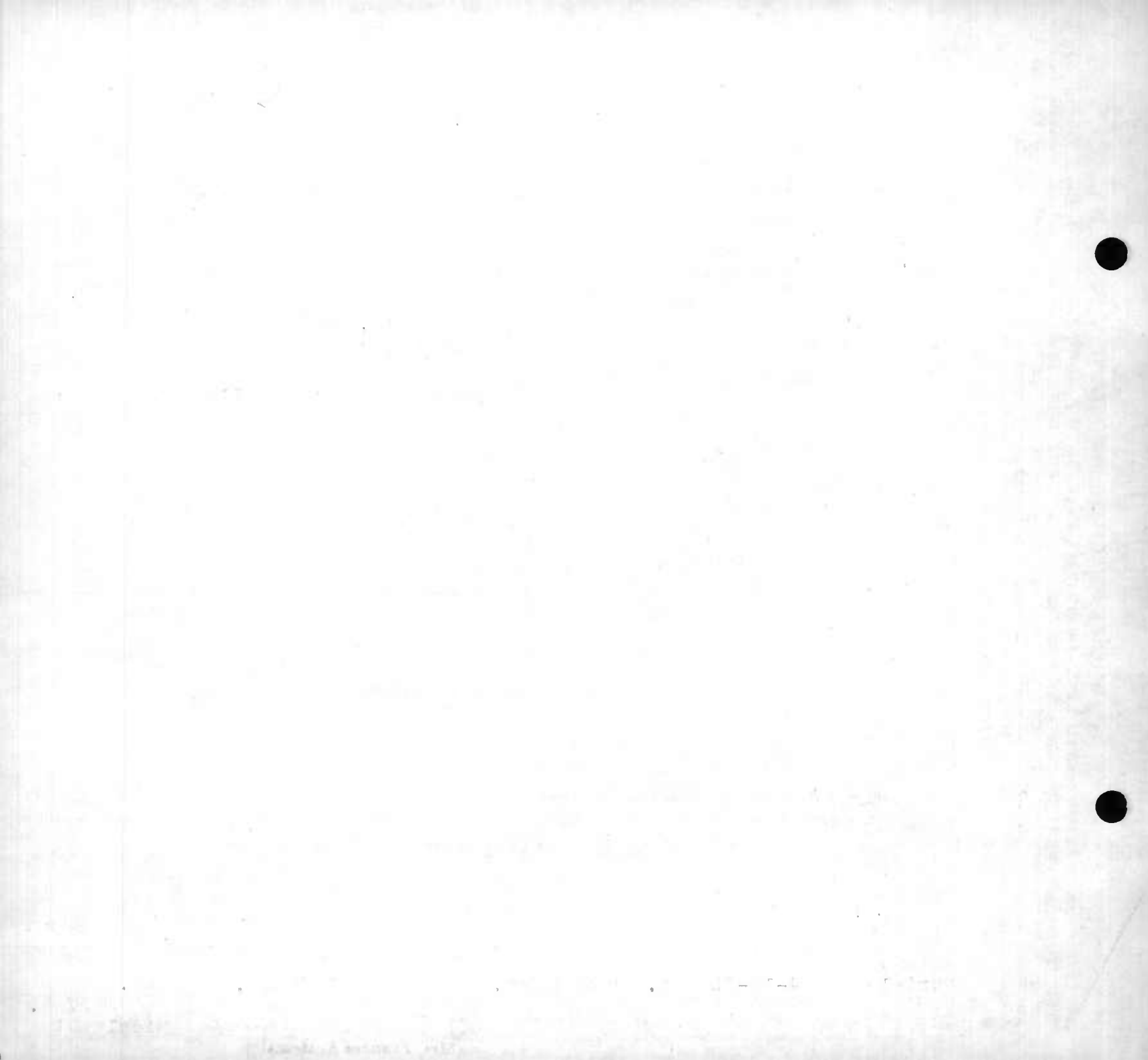




# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |   |  |  |  |   |  |   |  |                              |  |  |
|--|--|--|--|---|--|--|--|---|--|---|--|------------------------------|--|--|
| BIRTH NO. 65 3784  |  |  |  |   | CERTIFICATE OF DEATH   |  |  |   |  | Registered No. 65 3784                        |  |                              |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>William Payne</u>  |  |  |  |   | 2. DATE AND HOUR OF DEATH<br><u>4-6-65</u> <u>1055</u> M.  |  |  |   |  |   |  |                              |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>MERCY HOSPITAL</u>   |  |  |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u><br>D. STREET ADDRESS (If rural, give location) <u>204 N. Fremont Avenue</u> |  |  |   |  |   |  |                              |  |  |
| 5. SEX <u>M</u>  |  | 6. RACE <u>N</u>                                 |  | 7. MARRIED, NEVER MARRIED<br><u>WIDOWED, DIVORCED</u> (specify)   |  | 8. DATE OF BIRTH<br><u>7</u>                                 |  | 9. AGE (In years last birthday) <u>81</u>   |  | If Under 1 Yr. Months: Days: Hours: Min.      |  | If Under 24 Hrs. Hours: Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Retired</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u> |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u> |  |                              |  |  |
| 13. FATHER'S NAME<br><u>James Payne</u>  |  |  |  |   | 14. MOTHER'S MAIDEN NAME<br><u>Not Known</u>   |  |  |   |  |   |  |                              |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Unk.</u>  |  |  |  |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS<br><u>Gordon Payne 2207 Allendale Road</u>         |   |  |   |  |                              |  |  |
| 18. <u>4-20-11</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |  |   | CAUSE OF DEATH<br>(A) <u>Myocardial Infarction</u><br>DUE TO<br>(B) <u>ASCVD</u><br>DUE TO<br>(C) _____  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH              |  |                              |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |   |  |  |  |   |  |   |  |                              |  |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED |  |   | 20A. AUTOPSY? (Yes or No)<br><u>No</u>   |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |  |                              |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |   |  |                              |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |  | 21F. HOW DID INJURY OCCUR?   |   |  |   |  |                              |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-23</u> 19 <u>65</u> to <u>4-6</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4-6</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.      |  |  |  |   |  |  |  |   |  |   |  |                              |  |  |
| 23A. SIGNATURE<br><u>Perry S. Shelton</u> M.D.   |  |  |  |   |  |  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><u>4-7-65</u>             |  |                              |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Perry S. Shelton</u>  |  |  |  | 23D. ADDRESS<br><u>Mercy Hospital</u> M.D.  |  |  |  |   |  |   |  |                              |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>4-10-65</u>                      |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Mt. Auburn Cem.</u>  |  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore, Md.</u>   |   |  |   |  |                              |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 9 1965</u>   |  |  |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor</u>   |  |  | 25C. FUNERAL DIRECTOR<br><u>(Mrs) Frances A. Hensley</u>                 |   |  | ADDRESS <u>578W. Biddle St</u>                |  |                              |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |                         |  |  |                      |   |  |  |  |  |  |  |  |   |  |
|--|--|-------------------------|--|--|----------------------|---|--|--|--|--|--|--|--|---|--|
| BIRTH NO. 65 3785  |  |                         |  |  | CERTIFICATE OF DEATH |   |  |  |  | Registered No. 65 3785   |  |  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MACK MURPHY</b>  |  |                         |  |  |                      |   |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>April 7, 1965</b>  |  |  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |                         |  |  |                      |   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>27-18</b> |  |  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>SINAI HOSPITAL OF BALTIMORE, INC.</b>  |  |                         |  |  |                      |   |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>  |  |  |  |   |  |
|  |  |                         |  |  |                      |   |  |  |  | D. STREET ADDRESS (If rural, give location)<br><b>5406 Denmore Ave.</b>  |  |  |  |   |  |
| 5. SEX<br><b>Male</b>  |  | 6. RACE<br><b>Negro</b> |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                             |                      | 8. DATE OF BIRTH<br><b>6-9-90</b>                               |  | 9. AGE (In years lost birthday)<br><b>74</b>                             |  | If Under 1 Yr. Months: Days: Hours: Min.   |  | If Under 24 Hrs. Hours: Min.               |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired custodian-none</b>   |  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>public schools</b>   |                      |   |  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>       |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b> |  |   |  |
| 13. FATHER'S NAME<br><b>Unknown</b>  |  |                         |  |  |                      | 14. MOTHER'S MAIDEN NAME<br><b>Mary Procter</b>                 |  |  |  |  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes WW I</b>  |  |                         |  |  |                      | 16. SOCIAL SECURITY NO.<br><b>705-10-6302</b>                   |  | 17. INFORMANT ADDRESS<br><b>Mary Warrington 3511 Berwyn Ave.</b>         |  |  |  |  |  |   |  |
| 18. <b>465X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>Pulmonary emboli</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                         |  |  |                      |   |  |  |  | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO   |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs.</b> |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>ASCVD with recurrent myocardial infarction 2 months</b>  |  |                         |  |  |                      |   |  |  |  |  |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  |                         |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                      |   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  |                         |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                      |   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |                         |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                      |   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>2-19</b> 19 <b>65</b> to <b>4-7</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4-7</b> 3 pm 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                       |  |                         |  |  |                      |   |  |  |  |  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>RENARDUREZA</b>   |  |                         |  |  |                      |   |  |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>     |  | 23B. DATE SIGNED                           |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |                         |  |  |                      |   |  |  |  | 23D. ADDRESS<br><b>Sinai Hospital of Baltimore INC.</b>  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |                         |  | 24B. DATE<br><b>4/14/65</b>  |                      | 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore National</b> |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md</b>   |  |  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b>   |  |                         |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Stachurski</b>  |                      |   |  | 25C. FUNERAL DIRECTOR<br><b>Mar 7 501 &amp; Hyatt 638 N. G. Union St</b> |  |  |  | ADDRESS                                    |  |   |  |

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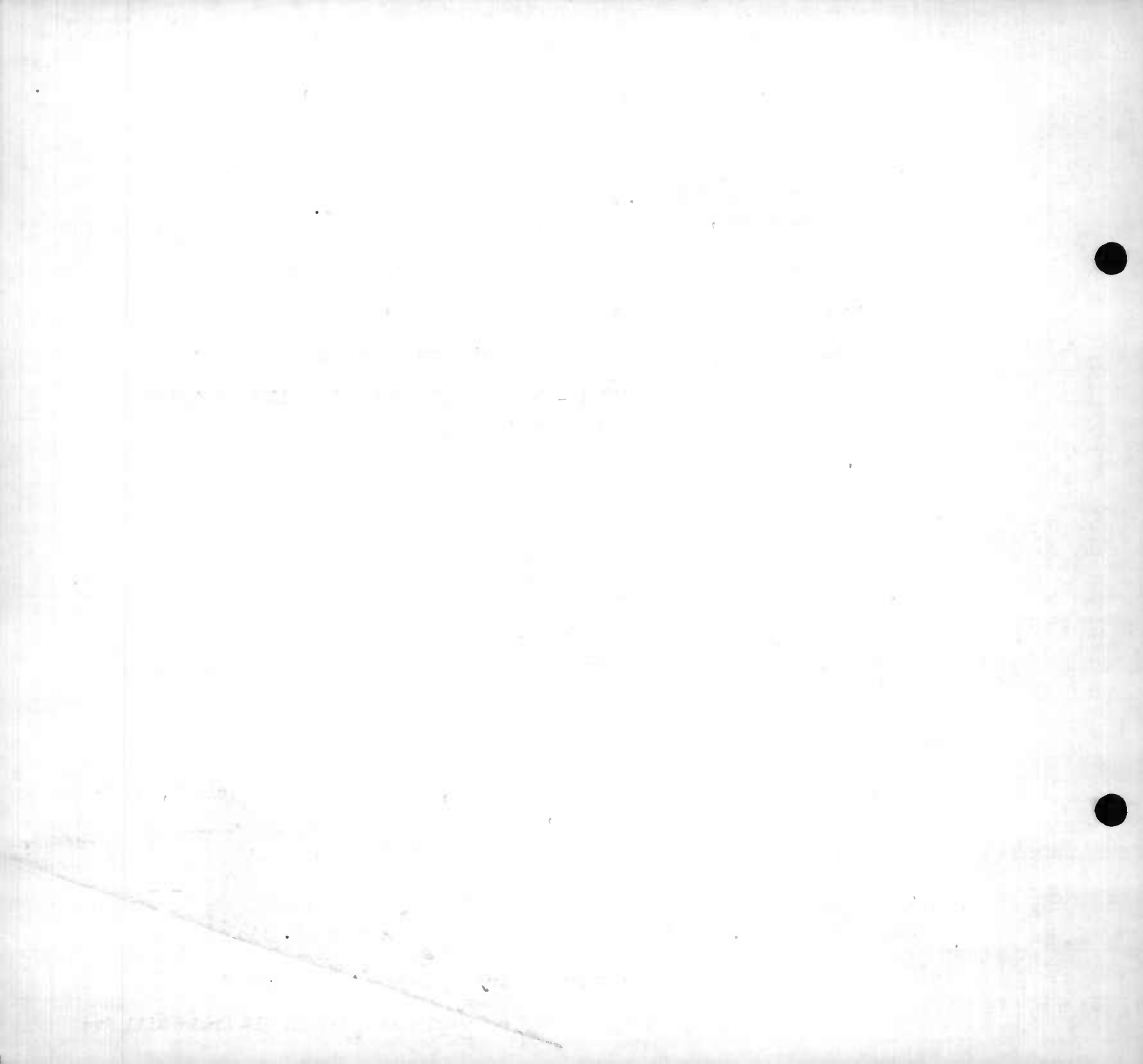
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |   |  |  |
|--|--|--|---|--|--|
| BIRTH NO. 65 3786  |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3786   |  |
| M.E. CASE NO.  |  |  | 1. NAME OF DECEASED<br>(Type or Print) Warren White   |  |  |
| 2. DATE AND HOUR OF DEATH<br>April 6, 1965 2:20 p.m.   |  |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Provident Hospital<br>1514 Division St.<br>Baltimore, Maryland 21217 |  |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore  |  | 5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Separated   |   |  |  |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore   |  | 8. DATE OF BIRTH<br>February 7, 1920   |   | 9. AGE (In years lost birthday) 45   |  |
| D. STREET ADDRESS (If rural, give location)<br>1123 Etting St.   |  | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer                               |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>Construction  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA  |   | 13. FATHER'S NAME<br>John T White  |  |
| 14. MOTHER'S MAIDEN NAME<br>Mildred Steverson  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)                             |   | 16. SOCIAL SECURITY NO.<br>219-10-5169   |  |
| 17. INFORMANT<br>Mrs Mildred White   |  | ADDRESS<br>1123 Etting St  |   | 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>INTERVAL BETWEEN ONSET AND DEATH<br>Antecedent Causes<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Bronchopneumonia |  |
| 19A. DATE OF OPERATION<br>0  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br>No  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 5, 1965 to April 6, 1965, and that (I) (we) last saw the deceased alive on April 6, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |   |  |  |
| 23A. SIGNATURE<br>Roland T. Smoot  |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |   | 23B. DATE SIGNED<br>4-6-65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Roland T. Smoot  |  | 23D. ADDRESS<br>1514 Division St.  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>4/10/65   |   | 24C. NAME OF CEMETERY OR CREMATORY<br>Mt Calvary Cemetery  |  |
| 24D. LOCATION<br>A A County Md   |  | 25A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965  |   |  |  |
| 25B. NAME OF REGISTRAR<br>Adolphus Hallstead   |  | 25C. FUNERAL DIRECTOR<br>Adolphus Hallstead  |   |  |  |
| ADDRESS<br>918 Druid Hill Ave  |  |  |   |  |  |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ISAAC BLANCHARD

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965

5:45 p M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

University Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

407 Myrtle Avenue

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9. AGE (In years  
lost birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Harvy Blanchard

14. MOTHER'S MAIDEN NAME

Florida

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
239-07-8503

17. INFORMANT

ADDRESS

Mr Otto Blanchard Brother 1401 Madison Ave

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/10/65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary Cemetery

23D. LOCATION

(City, town, or county)

A A County Md

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 9 1965

Robert E. Farley, M.D.

Agolpus Halstead 918 Druid Hill Ave



WALTER H. DUNN

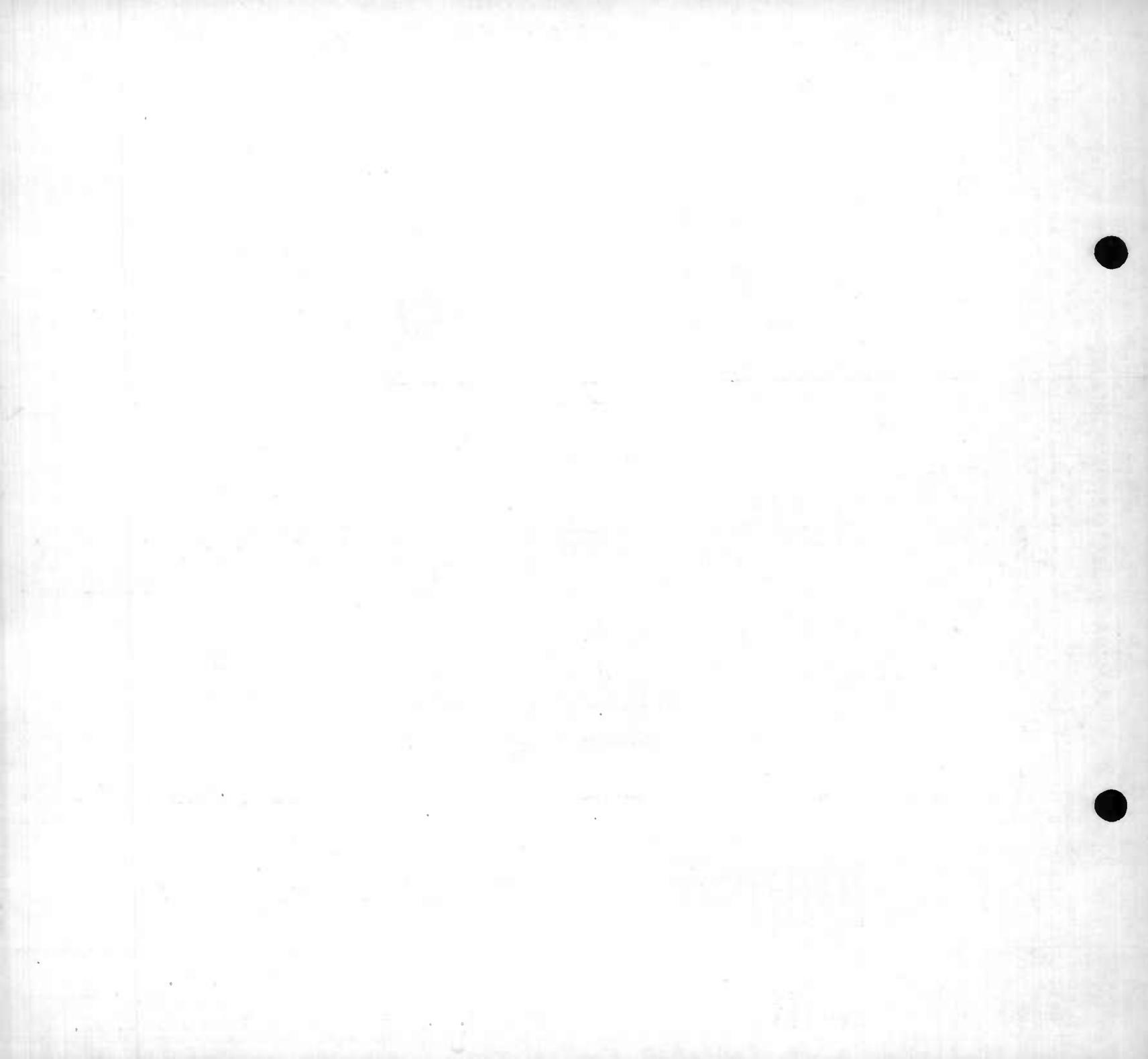
*W. H. Dunn*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |                     |  |  |  |                                    |  |  |  |  |  |                             |  |  |   |  |
|---|--|---------------------|--|--|--|------------------------------------|--|--|--|--|--|-----------------------------|--|--|---|--|
| BIRTH NO. 65 3788   |  |                     |  |  | CERTIFICATE OF DEATH   |                                    |  |  |  | Registered No. 65 3788   |  |                             |  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Mr. Arthur J. Lockerd</u>   |  |                     |  |  | 2. DATE AND HOUR OF DEATH<br><u>April 7, 1965</u>   <u>5:10 A.M.</u>   |                                    |  |  |  |  |  |                             |  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |                     |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                                    |  |  |  |  |  |                             |  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Maryland General Hospital</u>   |  |                     |  |  | A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u>  |                                    |  |  |  |  |  |                             |  |  |   |  |
|   |  |                     |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>Reisterstown</u>                                       |                                    |  |  |  |  |  |                             |  |  |   |  |
|   |  |                     |  |  | D. STREET ADDRESS (If rural, give location)<br><u>169 Westminster Pike</u>   |                                    |  |  |  |  |  |                             |  |  |   |  |
| 5. SEX<br><u>M</u>  |  | 6. RACE<br><u>W</u> |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><u>MARRIED</u> |  | 8. DATE OF BIRTH<br><u>1/28/97</u> |  | 9. AGE (in years last birthday)<br><u>68</u> |  | If Under 1 Yr. Months Days   |  | If Under 24 Hrs. Hours Min. |  |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>RETIRED</u>   |  |                     |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Chicken Hatchery</u>   |                                    |  |  |  | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>             |  |                             |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                                |  |
| 13. FATHER'S NAME<br><u>Winifred Lockerd</u>  |  |                     |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Mary Barnes</u>   |                                    |  |  |  |  |  |                             |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>Yes</u> <u>WW 1</u>  |  |                     |  |  | 16. SOCIAL SECURITY NO.<br><u>212-44-1185</u>  |                                    |  |  |  | 17. INFORMANT<br><u>Wife</u>   |  |                             |  |  | ADDRESS<br><u>SAME</u>  |  |
| 18. <u>451X I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><u>ACUTE RENAL FAILURE</u><br>DUE TO<br><u>AORTIC ANEURYSM (Abd.)</u><br>DUE TO<br><u>GENERALIZED ARTERIOSCLEROSIS</u>       |  |                     |  |  | CAUSE OF DEATH   |                                    |  |  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |                             |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                     |  |  |  |                                    |  |  |  |  |  |                             |  |  |   |  |
| 19A. DATE OF OPERATION<br><u>1/3/20/65</u>  |  |                     |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>AORTIC ANEURYSM</u>   |                                    |  |  |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                   |  |                             |  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  |                     |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |                             |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |                     |  |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>                               |                                    |  |  |  | 21F. HOW DID INJURY OCCUR?   |  |                             |  |  |   |  |
| 22. I certify that (this hospital) attended the deceased from <u>MARCH 19</u> 19 <u>65</u> to <u>MARCH April 7</u> 19 <u>65</u> , that (we) last saw the deceased alive on <u>April 7</u> 19 <u>65</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) <u>view</u> the body after death. |  |                     |  |  |  |                                    |  |  |  |  |  |                             |  |  |   |  |
| 23A. SIGNATURE<br><u>Bruce H. MacPherson</u>  |  |                     |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                    |  |  |  | 23B. DATE SIGNED<br><u>4/7/65</u>  |  |                             |  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |                     |  |  | 23D. ADDRESS<br>M.D.   |                                    |  |  |  |  |  |                             |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |  |                     |  |  | 24B. DATE<br><u>4/10/65</u>  |                                    |  |  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>All Saints</u>                  |  |                             |  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Reisterstown, Md.</u> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 9 1965</u>  |  |                     |  |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Farber, M.D.</u>  |                                    |  |  |  | 25C. FUNERAL DIRECTOR<br><u>J. F. Eline &amp; Sons</u>                   |  |                             |  |  | ADDRESS<br><u>Reisterstown, Md.</u>                                       |  |



1  
5-530

65 3789

BALTIMORE CITY HEALTH DEPARTMENT

65 3789

|   |         |  |   |  |   |
|---|---------|--|---|--|---|
| BIRTH NO.   |         | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |   | Registered No.   |   |
| M.E. CASE NO.   |         |  |   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  | 2. DATE AND HOUR PRONOUNCED DEAD  |  |   |
| PAUL SMITH  |         |  | April 3, 1965   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |   |
|   |         |  | A. STATE Maryland B. COUNTY   |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |         |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |  |   |
| 105 N. Carey St.  |         |  | Baltimore 18-02   |  |   |
| D. STREET ADDRESS (If rural, give location)   |         |  | 105 N. Carey St.  |  |   |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                       | 8. DATE OF BIRTH  | 9. AGE (In years lost birthday)  | 10. UNDER 1 Yr. If Under 24 Hrs. Months Days Hours Min. |
| male  | white   | SINGLE   | NOV 10 1903   | 61   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |   |
| PAINTER   |         | SELF-EMP.  |   | MD   |   |
| 13. FATHER'S NAME   |         |  | 14. MOTHER'S MAIDEN NAME  |  |   |
| Paul Smith Sr   |         |  | Lillie Patti  |  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |   |
|   |         |  |   | Family Nicorus   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  | CAUSE OF DEATH  |  |   |
| E974X   |         |  | Asphyxia  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |         |  | (A) DUE TO  |  |   |
|   |         |  | hanging   |  |   |
|   |         |  | (B) DUE TO  |  |   |
|   |         |  | (C) DUE TO  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |   |  |   |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
| D   |         |  |   | NO   |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)      |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
|   |         | Home   |   | 105 N. Carey St.   |   |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?   |   |
| (Month) (Day) (Year) (Hour)   |         | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |   | Hung self  |   |
| 4 3 65 ?  |         |  |   |  |   |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |  |   |  |   |
| ACTUAL SIGNATURE  |         | CHIEF MEDICAL EXAMINER   |   | DATE SIGNED  |   |
| EXAMINER'S NAME (Type) Rudiger Breiteneker  |         | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>                          |   | 4-4-65   |   |
| ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>   |         |  |   |  |   |
| 23A. BURIAL CREMATION, REMOVAL (Specify)  |         | 23B. DATE  |   | 23C. NAME OF CEMETERY or CREMATORY                                       |   |
| Burial  |         | 4-8-65   |   | Loudon Park Cem.   |   |
| 24A. DATE REC'D BY HEALTH DEPT.   |         | 24B. NAME OF REGISTRAR   |   | 24C. FUNERAL DIRECTOR ADDRESS  |   |
| APR 9 1965  |         | Robert E. Taylor, M.D.   |   | C. F. Evans, Son 8802 Hartford Rd  |   |

N991X 9650003798

VALLEY HOPE

PAID CONTENT

*W. H. H. H.*



VALLEY FORGE

Nov. 1, 1793

General Skene

General Skene  
Philadelphia, Pa.

Philadelphia, Pa.

General Skene

Nov. 1, 1793

General Skene

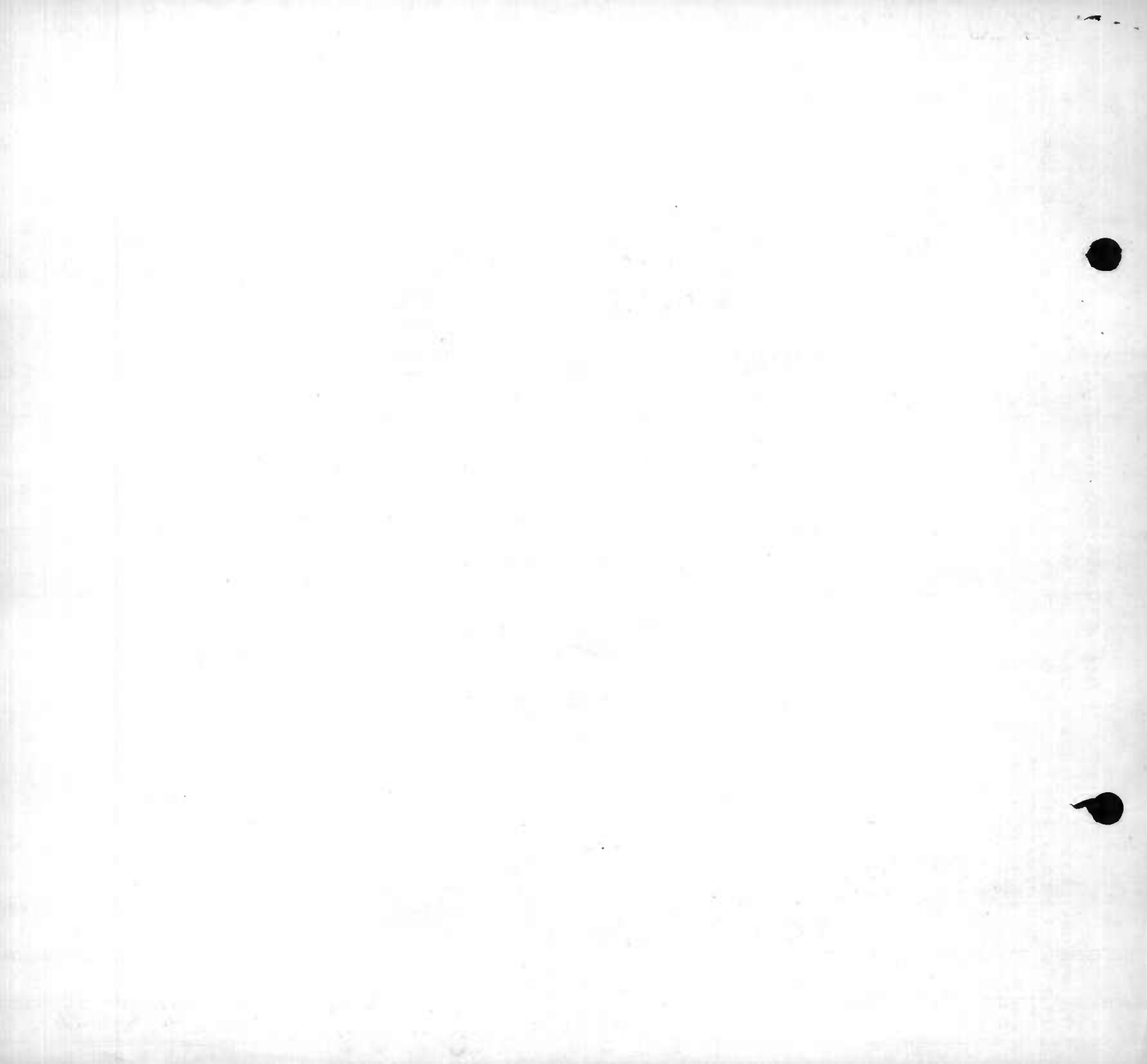
William R. Skene



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | Registered No.  |  | 65 3791   |  |
|--|--|--|--|---|--|---|--|
| BIRTH NO. 65 3791  |  | CERTIFICATE OF DEATH   |  |   |  |   |  |
| M.E. CASE NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>HERBERT J. Knapp</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>April 5 1965</b> <b>11:00 P.M.</b>                          |  |   |  |
| 3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A, STATE <b>MD</b><br>B, COUNTY <b>Balt</b> |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>PARKVILLE</b> |  | D. STREET ADDRESS (If rural, give location)<br><b>8807 Wilson Ave</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>HOUSE-IN-PINES, BELAIR</b>  |  | (If not in hospital or institution, give street address or location)   |  | 5. SEX <b>M</b>   |  | 6. RACE <b>W</b>  |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>WIDOWER</b>   |  | 8. DATE OF BIRTH<br><b>MAY 24 1884</b>   |  | 9. AGE (In years last birthday)<br><b>80</b>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Civil Service</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                                |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                            |  |
| 13. FATHER'S NAME<br><b>HENRY Knapp</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNA THURN</b>  |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |  | ADDRESS   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES WWI</b>   |  | 16. SOCIAL SECURITY NO.<br><b>220-44-7002</b>  |  | 17. INFORMANT<br><b>FAMILY RECORDS</b>  |  | ADDRESS   |  |
| 18. <b>420.01</b>  |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) <b>Acute Pulmonary Edema</b>   |  | <b>3 hrs</b>  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) <b>Congestive Heart Failure</b>  |  | <b>Years</b>  |  |   |  |
| (C) <b>Arteriosclerotic Heart Disease</b>  |  |  |  | <b>" "</b>  |  |   |  |
| II   |  |  |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                    |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>March 22 1965</b> to <b>April 5 1965</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>April 4 1965</b> and that in (my) ( <del>the</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) (did not) view the body after death. |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Albert D. Dudley</b>  |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><b>4/7/65</b>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ALBERT B. BRADLEY</b>   |  | M.D. <b>4900 BELAIR RD</b>   |  | 23D. ADDRESS  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>4-7-65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>LOUDON PARK CEM</b>                                |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTO MD</b>      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>C. F. FURRY &amp; SON</b>                                       |  | ADDRESS<br><b>8802 Hartwood Rd</b>                                    |  |





## BALTIMORE CITY HEALTH DEPARTMENT

|  |                  |  |                              |   |   |
|--|------------------|--|------------------------------|---|---|
| BIRTH NO. 65 3792  |                  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |                              | Registered No. 65 3792  |   |
| M.E. CASE NO.  |                  |  |                              | 2. DATE AND HOUR PRONOUNCED DEAD<br>April 6, 1965 6:45 p.m.   |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br>JOHN P. ROHNACHER  |                  |  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>40 St. Agnes Hospital   |                  |  |                              | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore 20-08<br>D. STREET ADDRESS (If rural, give location)<br>152 S. Collins Avenue |   |
| 5. SEX<br>male   | 6. RACE<br>white | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>MARRIED  | 8. DATE OF BIRTH<br>12/30/34 | 9. AGE (In years lost birthday)<br>31 30  | If Under 1 Yr. If Under 24 Hrs.<br>Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>SALESMAN  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Hardware Store  |                              | 11. BIRTHPLACE (State or foreign country)<br>BALTO. Md.   |   |
| 13. FATHER'S NAME<br>Bernhardt Rohnacher   |                  | 14. MOTHER'S MAIDEN NAME<br>Bertha Von Bussenuis   |                              | 12. CITIZEN OF WHAT COUNTRY?  |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes 4/10/53-5/22/53   |                  | 16. SOCIAL SECURITY NO.<br>204-30-4948   |                              | 17. INFORMANT<br>Mrs. Betty Lou C. Rohnacher  |   |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Fracture of the neck<br>DUE TO<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                  |  |                              | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                              | 20A. AUTOPSY? (Yes or No)<br>no   |   |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street   |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>Frederick Avenue so. of Augusta Avenue  |   |
| 21D. TIME OF INJURY (APPROX.)<br>4 6 65 6:35 p.m.  |                  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |                              | 21F. HOW DID INJURY OCCUR?<br>Pedestrian struck by auto   |   |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  |                  |  |                              |   |   |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type)<br>Rudiger Breitenecker  |                  | M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |                              | DATE SIGNED<br>4-7-65   |   |
| 23A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 23B. DATE<br>4/9/65  |                              | 23C. NAME OF CEMETERY or CREMATORY<br>BALTO. NAT. CEM.  |   |
| 24A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965  |                  | 24B. NAME OF REGISTRAR<br>Robert E. Taylor   |                              | 24C. FUNERAL DIRECTOR<br>G. Truman Schwab   |   |
|  |                  |  |                              | 24D. LOCATION (City, town, or county) (State)<br>BALTO. Md.   |   |

VALLEY POLICE

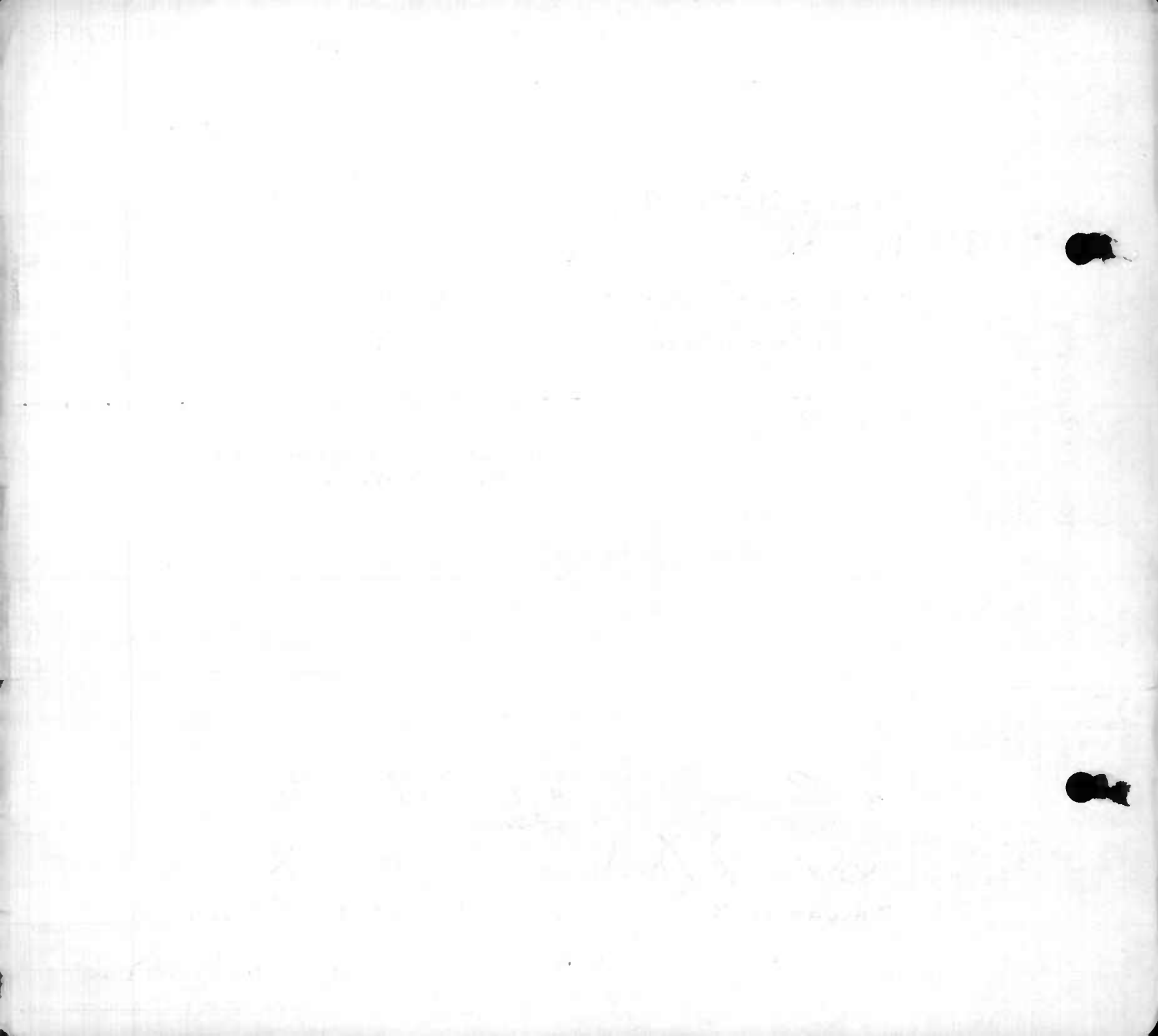
DEPT. OF JUSTICE

*[Handwritten signature]*

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |   |   |  | Registered No. <span style="font-size: 1.2em;">65 3793</span>   |  |
|--|---|---|--|---|--|
| BIRTH NO. <span style="font-size: 1.2em;">65 3793</span>   |   | <b>CERTIFICATE OF DEATH</b>   |  |   |  |
| M.E. CASE NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">GEORGE H. ROBINETTE</span>   |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">4-8-65</span> <span style="font-size: 1.2em;">6:15</span> A.M. |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.2em;">MERCY HOSPITAL</span>  |   | A. STATE <span style="font-size: 1.2em;">MARYLAND</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>   |  |   |  |
| (If not in hospital or institution, give street address or location)   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.2em;">Essex (21)</span> <span style="font-size: 1.2em;">53-00</span> |  |   |  |
|  |   | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.2em;">1637 APT. A - EASTERN AVE</span>   |  |   |  |
| 5. SEX<br><span style="font-size: 1.2em;">M</span>   | 6. RACE<br><span style="font-size: 1.2em;">W</span> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.2em;">MARRIED</span>  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">4-12-11</span> | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">53</span>  | 10. Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Oiler and Greaser</span>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">Steel Mill</span>  |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Virginia</span>                                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">USA</span>   |   | 13. FATHER'S NAME<br><span style="font-size: 1.2em;">John Creed Robinette</span>  |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Christine Wells</span>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>  |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">407-09-7636</span>   |  | 17. INFORMANT ADDRESS<br><span style="font-size: 1.2em;">Eddie Robinette 44 Blister St. Balto. 20, Md.</span>               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.2em;">190.9 I</span><br><span style="font-size: 1.2em;">(A) MALIGNANT MELANOMA WITH METASTASIS</span>  |   | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   | (B) DUE TO  |  | (C) DUE TO  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |   |  |   |  |
| 19A. DATE OF OPERATION   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-8</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">4-8</span> 19 <span style="font-size: 1.2em;">65</span> , that (1) (we) lost saw the deceased alive on <span style="font-size: 1.2em;">4-7</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |   |   |  |   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Salvatore R. Donohue</span> M.D.   |   |   |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">4-8-65</span>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">SALVATORE R. DONOHUE</span> M.D.   |   | 23D. ADDRESS<br><span style="font-size: 1.2em;">MERCY HOSPITAL</span>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Removal</span>   |   | 24B. DATE<br><span style="font-size: 1.2em;">4/8/65</span>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Roy Greene Funeral Home</span>                        |  |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Appalachia, Virginia</span>   |   | 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">APR 9 1965</span>  |  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Fisher M.D.</span>                                      |  |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Brzdzinski Funeral Home</span>  |   | ADDRESS<br><span style="font-size: 1.2em;">1407 Eastern Ave.</span>   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3794  |                  |   |                              | BALTIMORE CITY HEALTH DEPARTMENT  |                       | Registered No. 65 3794   |                       |
|--|------------------|---|------------------------------|---|-----------------------|--|-----------------------|
| M.E. CASE NO.  |                  |   |                              | CERTIFICATE OF DEATH  |                       |  |                       |
| 1. NAME OF DECEASED<br>(Type or Print) MEYER (MAYER) DUNN  |                  |   |                              | 2. DATE AND HOUR OF DEATH<br>April 8, 1965 4:20 A.M.  |                       |  |                       |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                  |   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                       |  |                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Sinai Hospital of Baltimore, Inc.  |                  |   |                              | A. STATE B. COUNTY<br>Maryland, Baltimore   |                       |  |                       |
|  |                  |   |                              | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore #8 53700   |                       |  |                       |
|  |                  |   |                              | D. STREET ADDRESS (If rural, give location)<br>3307 Smith Ave.  |                       |  |                       |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Widowed                                       | 8. DATE OF BIRTH<br>12-20-85 | 9. AGE (In years lost birthday)<br>79   | If Under 1 Yr. Months | If Under 24 Hrs. Days  | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>+ REPAIR  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>SHOES  |                              | 11. BIRTHPLACE (State or foreign country)<br>Poland   |                       | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                               |                       |
| 13. FATHER'S NAME<br>HYMAN WOLF DUNN   |                  |   |                              | 14. MOTHER'S MAIDEN NAME<br>BRINA ?   |                       |  |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.<br>214-34-4624  |                              | 17. INFORMANT ADDRESS<br>MRS. ANN CAPLAN 3307 SMITH AVENUE  |                       |  |                       |
| 18. CAUSE OF DEATH   |                  |   |                              | INTERVAL BETWEEN ONSET AND DEATH  |                       |  |                       |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |                              | (A) DUE TO Pulmonary edema<br>two hours<br>(B) DUE TO Diabetic ketoacidosis, CVA<br>two days<br>(C) Bleeding ruptured anterior duodenal ulcer<br>14 days (25 years history) |                       |  |                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Peritonitis - secondary to Intraperitoneal leakage of GI secretions  |                  |   |                              |   |                       |  |                       |
| 19A. DATE OF OPERATION<br>3-26-65  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Hemorrhage from ruptured anterior duodenal ulcer      |                              | 20A. AUTOPSY? (Yes or No)   |                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                       |  |                       |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                              | 21F. HOW DID INJURY OCCUR?  |                       |  |                       |
| 22. I certify that (I) (this hospital) attended the deceased from 3-26-1965 to 4-8-1965, that (I) (we) last saw the deceased alive on 4-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                          |                  |   |                              |   |                       |  |                       |
| 23A. SIGNATURE<br>Bernas ELVERO  |                  |   |                              | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                       | 23B. DATE SIGNED<br>4-8-65   |                       |
| 23C. PHYSICIAN'S NAME (Type)<br>BERNAS ELVERO  |                  |   |                              | 23D. ADDRESS<br>M.D. SINAI HOSPITAL   |                       |  |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>4/9/65   |                              | 24C. NAME OF CEMETERY or CREMATORY<br>SHAAREI ZION  |                       | 24D. LOCATION (City, town, or county) (State)<br>ROSEDALE MARYLAND   |                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor M.D.   |                              | 25C. FUNERAL DIRECTOR ADDRESS<br>SOB LEVINSON & BROS. INC. 6010 REISTERSTOWN RD   |                       |  |                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |           |   |                               | Certificate of Death  |  | Registered No. 65 3795   |  |
|---|-----------|---|-------------------------------|---|--|--|--|
| BIRTH NO. 65 3795   |           | M.E. CASE NO.   |                               | 1. NAME OF DECEASED<br>(Type or Print) ANNA E. JACK.  |  | 2. DATE AND HOUR OF DEATH<br>6. 7. '65 4 <sup>10</sup> / <sub>a</sub> M. |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>CHURCH HOME & HOSPITAL   |           |   |                               | 4. USUAL RESIDENCE (Where deceased lived, If institution; residence before admission)<br>A. STATE MD B. COUNTY BALTIMORE<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) DUNDALK 21222 53-00<br>D. STREET ADDRESS (If rural, give location) 6814 BELCLARE ROAD |  |  |  |
| 5. SEX F  | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br>Married.  | 8. DATE OF BIRTH<br>6. 7. 87. | 9. AGE (In years last birthday)<br>77 yrs   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |           | 10B. KIND OF BUSINESS OR INDUSTRY   |                               | 11. BIRTHPLACE (State or foreign country)<br>MD. BALTI.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                   |  |
| 13. FATHER'S NAME<br>William H. Wagner  |           |   |                               | 14. MOTHER'S MAIDEN NAME<br>Mary McKinney.  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |           | 16. SOCIAL SECURITY NO.<br>219/14/1937  |                               | 17. INFORMANT<br>Mrs Anna E. Jack.  |  | ADDRESS<br>As above.   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>In Intestinal Obstruction<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Metastatic Ca. of pancreas<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |           |   |                               | INTERVAL BETWEEN ONSET AND DEATH<br>4 wks.<br>2 1/2 yrs.  |  |  |  |
| 19A. DATE OF OPERATION  |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                               | 20A. AUTOPSY? (Yes or No)<br>NO.  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |           | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                               | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3. 27. 19 65 to 4. 7. 1965, that (I) (we) last saw the deceased alive on 4. 7. 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |           |   |                               |   |  |  |  |
| 23A. SIGNATURE<br>M. Bashir Ulvi  |           |   |                               | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stiff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>M. BASHIR ULVI  |           |   |                               | 23D. ADDRESS<br>CHURCH, Home and Hospital Baltimore   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL  |           | 24B. DATE<br>4/9/1965   |                               | 24C. NAME OF CEMETERY or CREMATORY<br>OAK LAWN  |  | 24D. LOCATION<br>BALTIMORE COUNTY, MD                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965   |           | 25B. NAME OF REGISTRAR<br>R. E. J. J. J.  |                               | 25C. FUNERAL DIRECTOR<br>C. B. BRADLEY  |  | ADDRESS<br>DUNDALK, MD.  |  |



W. BACHMANN  
J. P. BACHMANN

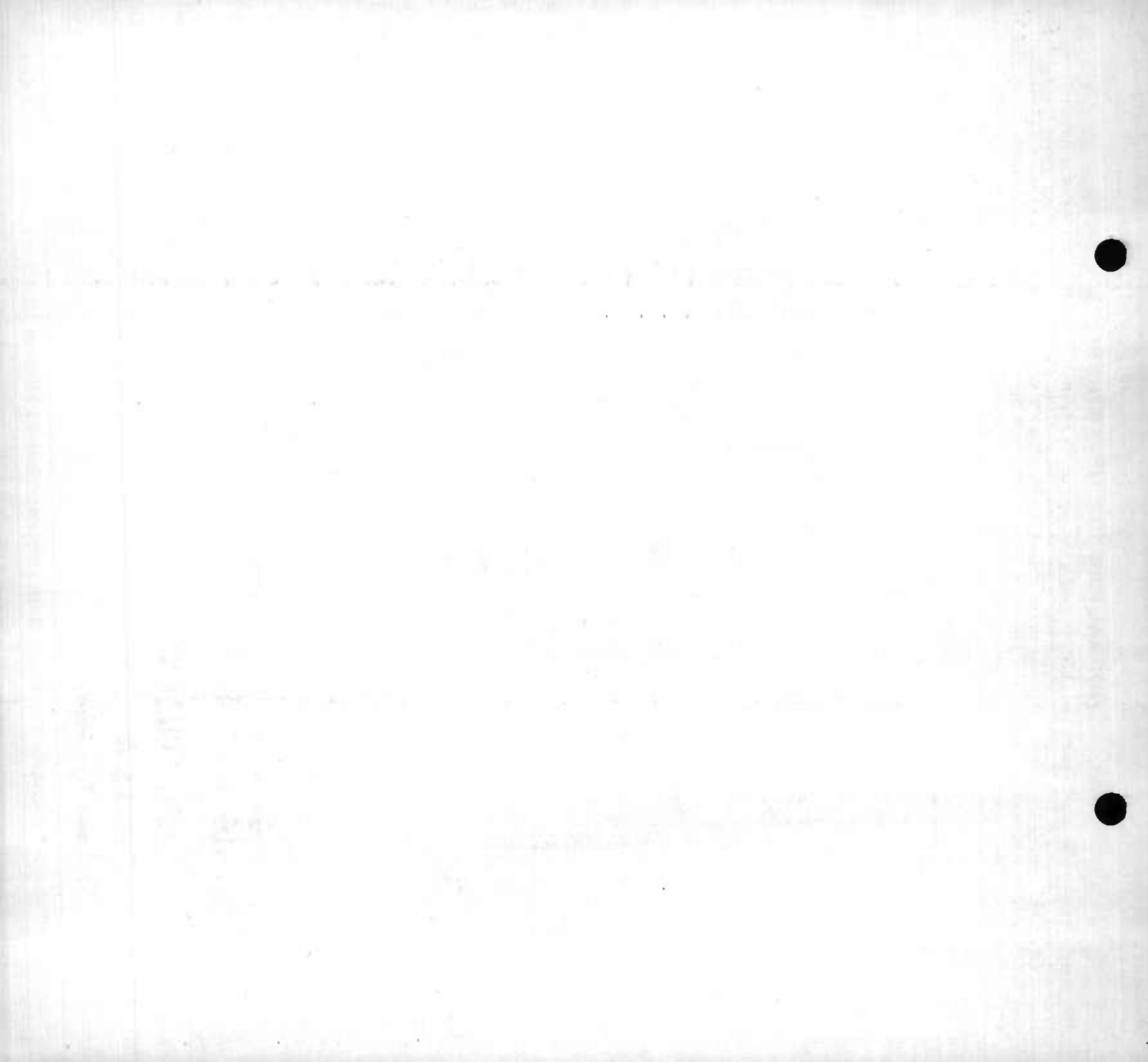
CHARGE, H. M. BACHMANN



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

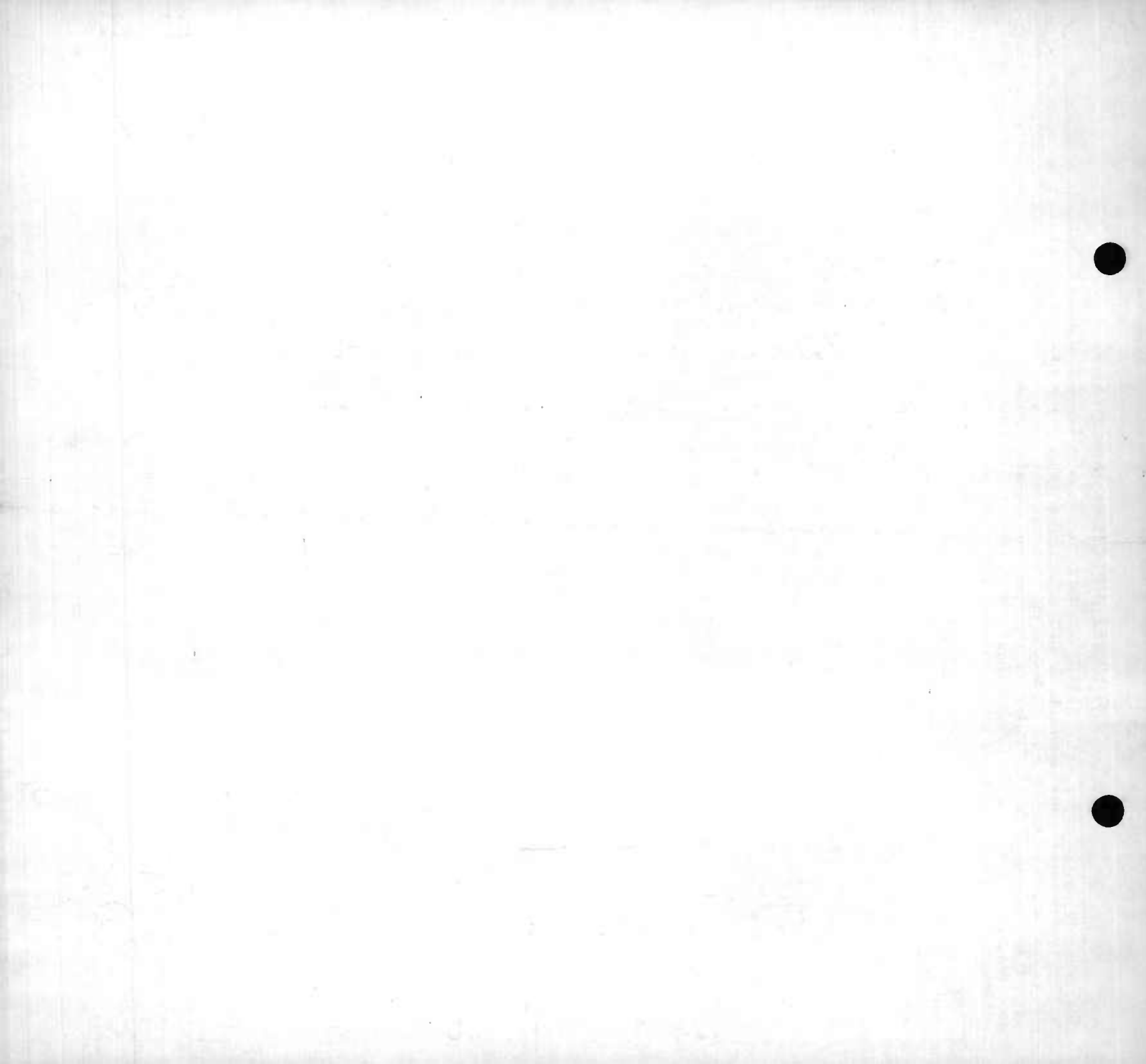
| BALTIMORE CITY HEALTH DEPARTMENT   |   |  |   | Registered No. <span style="font-size: 1.2em;">65 3796</span>   |   |
|--|---|--|---|---|---|
| BIRTH NO. <span style="font-size: 1.2em;">65 3796</span>   |   | <b>CERTIFICATE OF DEATH</b>  |   |   |   |
| M.E. CASE NO.  |   |  | DATE AND HOUR OF DEATH  |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.1em;">James J. McGrath</span>   |   |  | April 4-1965 11:30 P.M.   |   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                       |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |   |  | A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">27-48</span>             |   |   |
| <span style="font-size: 1.1em;">746 E. Lake Avenue</span>  |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.1em;">Baltimore</span> |   |   |
|  |   |  | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.1em;">746 E. Lake Avenue</span>                    |   |   |
| 5. SEX<br><span style="font-size: 1.1em;">Male</span>  | 6. RACE<br><span style="font-size: 1.1em;">White</span> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.1em;">Widowed</span>                             | 8. DATE OF BIRTH<br><span style="font-size: 1.1em;">Aug. 10, 1871-93-</span>  | 9. AGE (In years last birthday)<br><span style="font-size: 1.1em;">84</span>                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.1em;">Clerk - retired</span>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.1em;">U.S.F. &amp; G.</span>  |   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.1em;">Baltimore, Maryland</span>     |   |
| 13. FATHER'S NAME<br><span style="font-size: 1.1em;">Patrick McGrath</span>  |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.1em;">Catherine Butler</span>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.1em;">USA</span>                                  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.1em;">No</span>  |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.1em;">212-20-2403</span>  |   | 17. INFORMANT<br><span style="font-size: 1.1em;">Mrs. Margaret M. Spilman</span>                            |   |
|  |   |  |   | ADDRESS<br><span style="font-size: 1.1em;">746 E. Lake Ave</span>   |   |
| 18. <span style="font-size: 1.2em;">420.01</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |   |  | CAUSE OF DEATH  |   |   |
|  |   |  | (A) DUE TO <span style="font-size: 1.2em;">Congestive Heart Failure</span>  |   |   |
|  |   |  | (B) DUE TO <span style="font-size: 1.2em;">Arteriosclerotic Heart Disease</span>  |   |   |
|  |   |  | (C) DUE TO <span style="font-size: 1.2em;">Chr. Arthritis</span>  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   |  |   |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  | <span style="font-size: 1.2em;">Chr Arthritis</span>  |   |   |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.1em;">0</span>   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <span style="font-size: 1.1em;">No</span>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                    |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) <del>(this hospital)</del> attended the deceased from <span style="font-size: 1.1em;">June 1 - 1962</span> to <span style="font-size: 1.1em;">April 4 - 1965</span> , that (I) <del>(we)</del> last saw the deceased alive on <span style="font-size: 1.1em;">April 4 - 1965</span> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death. |   |  |   |   |   |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Wm. G. Geyer</span>  |   | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |   | 23B. DATE SIGNED<br><span style="font-size: 1.1em;">April 6-65</span>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.1em;">WILLIAM-G. GEYER</span>  |   | 23D. ADDRESS<br><span style="font-size: 1.1em;">156 N. Milton Ave. Balt. 7+Md.</span>  |   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.1em;">Burial</span>  |   | 24B. DATE<br><span style="font-size: 1.1em;">4/8/65</span>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.1em;">New Cathedral Cemetery</span>         |   |
|  |   |  |   | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.1em;">Baltimore, Maryland</span> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.1em;">APR 9 1965</span>   |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.1em;">Robert E. Sullivan</span>  |   | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.1em;">John A. Moran, Inc.</span>                         |   |
|  |   |  |   | ADDRESS<br><span style="font-size: 1.1em;">3000 E. Balto. St.</span>  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

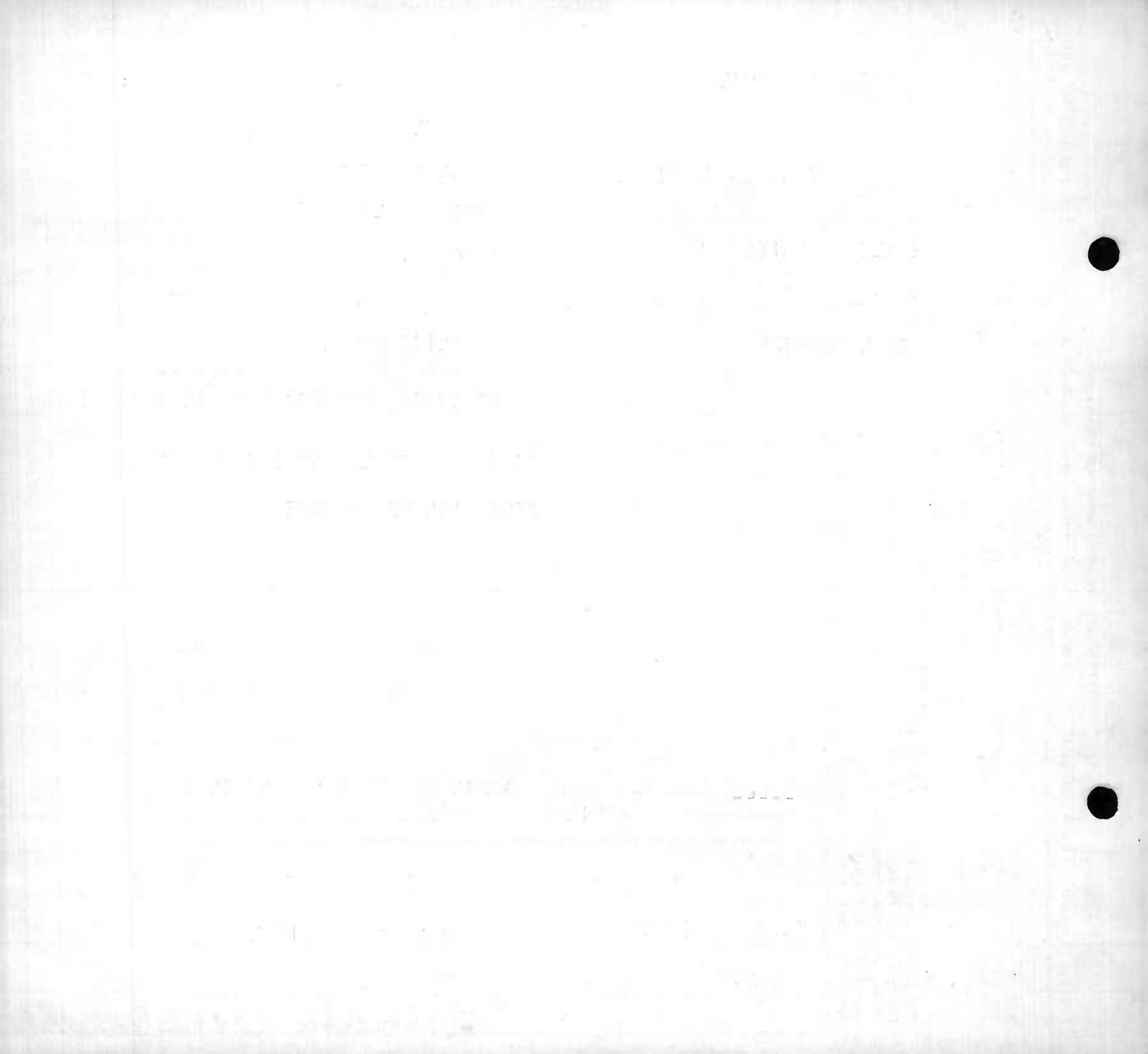
| BIRTH NO. 65 3797   |                         |   |                                     | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3797   |  |
|---|-------------------------|---|-------------------------------------|--|--|--|--|
| M.E. CASE NO.   |                         |   |                                     | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Elsie M. Butler</i>   |                         |   |                                     | 2. DATE AND HOUR OF DEATH<br><i>April 5, 1965 12 noon M.</i>   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>126 S. Gilmore Street</i>   |                         |   |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY <i>1904</i>   |  |  |  |
|   |                         |   |                                     | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>  |  |  |  |
|   |                         |   |                                     | D. STREET ADDRESS (If rural, give location)<br><i>126 S. Gilmore St.</i>   |  |  |  |
| 5. SEX<br><i>Female</i>   | 6. RACE<br><i>White</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Widowed</i>                                | 8. DATE OF BIRTH<br><i>5-8-1882</i> | 9. AGE (In years last birthday)<br><i>82 y.</i>  | If Under 1 Yr. Months Days If Under 24 Hrs. Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired seamstress</i>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Sewing Factory</i>  |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                          |  |
| 13. FATHER'S NAME<br><i>Nathan Bair</i>   |                         |   |                                     | 14. MOTHER'S MAIDEN NAME<br><i>Lucretia Green</i>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>   |                         | 16. SOCIAL SECURITY NO.<br><i>212-01-4461</i>   |                                     | 17. INFORMANT<br><i>Mrs. Geo. Beall, Registerstown Md</i>  |  | ADDRESS <i>21136</i>   |  |
| 18. <i>420.01</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                         |   |                                     | CAUSE OF DEATH<br>(A) <i>Arteriosclerotic Dis</i><br>DUE TO<br>(B) <i>Arteriosclerosis</i><br>DUE TO<br>(C) <i>—</i>                 |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>6 mo 1 y.</i>                   |  |
| MEDICAL CERTIFICATION<br>19A. DATE OF OPERATION<br><i>0</i>   |                         |   |                                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                     | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>5/24 65</i> to <i>62 4/5</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4/3</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |                         |   |                                     |  |  |  |  |
| 23A. SIGNATURE<br><i>George Vash</i>  |                         |   |                                     | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><i>4/5/65</i>                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>George VASH</i>  |                         |   |                                     | 23D. ADDRESS<br><i>206, S. Gilmore St., Balt</i>   |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>  |                         | 24B. DATE<br><i>4-7-1965</i>  |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><i>ST. JAMES</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>CARROLL Co. Md</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 9 1965</i>  |                         | 25B. NAME OF REGISTRAR<br><i>Robert S. ...</i>  |                                     | 25C. FUNERAL DIRECTOR<br><i>Carroll Co.</i>  |  | ADDRESS<br><i>Box 241 Sykesville Md.</i>                               |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3798   |               |  |  | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3798  |                                  |
|---|---------------|--|--|--|---|---|----------------------------------|
| M.E. CASE NO. 65 3798   |               |  |  | 1. NAME OF DECEASED (Type or Print) MCCABE THELMA  |   | 2. DATE AND HOUR OF DEATH APRIL 6 1965 3:00P M.                         |                                  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |               |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY |   | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) |                                  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST AGNES HOSPITAL   |               |  |  | MARYLAND   |   | BALTIMORE 27  |                                  |
|   |               |  |  | D. STREET ADDRESS (If rural, give location)  |   | 4921 SHELBOURNE RD  |                                  |
| 5. SEX FEMALE   | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)  | 8. DATE OF BIRTH 12/15/16                  | 9. AGE (In years lost birthday) 48   | If Under 1 Yr. Months Days  | If Under 24 Hrs. Hours Min.   |                                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Housework  |               |  | 10B. KIND OF BUSINESS OR INDUSTRY Own Home |  | 11. BIRTHPLACE (State or foreign country) Maryland                      |   | 12. CITIZEN OF WHAT COUNTRY? USA |
| 13. FATHER'S NAME EARL SUMMERS  |               |  | 14. MOTHER'S MAIDEN NAME ALICE DURHAM      |  |   |   |                                  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |               |  | 16. SOCIAL SECURITY NO. 213-12-4352        |  | 17. INFORMANT ADDRESS BALTO 29 MD ST AGNES HOSP RECORDS WILKENS & CATON |   |                                  |
| 18. 331X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)  |               |  |  | (A) CEREBRO VASCULAR ACCIDENT DUE TO   |   | INTERVAL BETWEEN ONSET AND DEATH 2 DAYS                                 |                                  |
| ANTECEDENT CAUSES   |               |  |  | (B) CEREBRIAL HEMORRHAGE DUE TO  |   |   |                                  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |               |  |  | (C)  |   |   |                                  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |               |  |  |  |   |   |                                  |
| 19A. DATE OF OPERATION 0  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |                                  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |   |   |                                  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |   |                                  |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 4 19 65 to APRIL 6 19 65, that (I) (we) lost saw the deceased alive on APRIL 6 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |  |  |  |   |   |                                  |
| 23A. SIGNATURE (Signature) M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |               |  |  | 23B. DATE SIGNED 4 6 65  |   |   |                                  |
| 23C. PHYSICIAN'S NAME (Type) MANUEL J RODRIQUEZ M.D.  |               |  |  | 23D. ADDRESS ST AGNES HOSPITAL   |   |   |                                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |               | 24B. DATE 4/9/65   |  | 24C. NAME OF CEMETERY or CREMATORY London Park Cemetery  |   | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland       |                                  |
| 25A. DATE REC'D BY HEALTH DEPT APR 9 1965   |               | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |   | ADDRESS   |                                  |
|   |               |  |  | Blair & Co Inc 1328 Sulphur Sp Rd  |   |   |                                  |



## CERTIFICATE OF DEATH

Registered No. 65 3799

BIRTH NO. 65 3799

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Harry Gardner SR.

2. DATE AND HOUR OF DEATH

4-7-1965

7 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland-212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1124 Steelton Avenue, 21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Separated

8. DATE OF BIRTH

9-11-1909

9. AGE (In years  
last birthday)

55

If Under 1 Yr.  
Months DaysIf Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

CONTRACTOR

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

UNK.

14. MOTHER'S MAIDEN NAME

UNK.

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

218-09-8351

17. INFORMANT  
HARRY W GARDNER JR. 7951  
Records: BCH-4940 Eastern Avenue, 21224  
ADDRESS  
6048 ST

18. 443X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) Uremia  
DUE TO Arteriosclerotic Cerebral  
Vascular Disease, Hypertensive  
(B) Cardio Vascular Disease  
DUE TO

6 days

5 years

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Multiple Cerebral Accidents

5 years

19A. DATE OF OPERATION

D

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 2-5-1965 to 4-7-1965,  
that (I) (we) last saw the deceased alive on 4-7-1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Marvin Schuster

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

4-7-1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Marvin Schuster

M.D.

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Maryland

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

BURIAL 4-10-65

LONDON PARK

BALTO MD.

25A. DATE REC'D BY HEALTH DEPT

APR 9 1965

25B. NAME OF REGISTRAR

Robert E. Schuster

25C. FUNERAL DIRECTOR

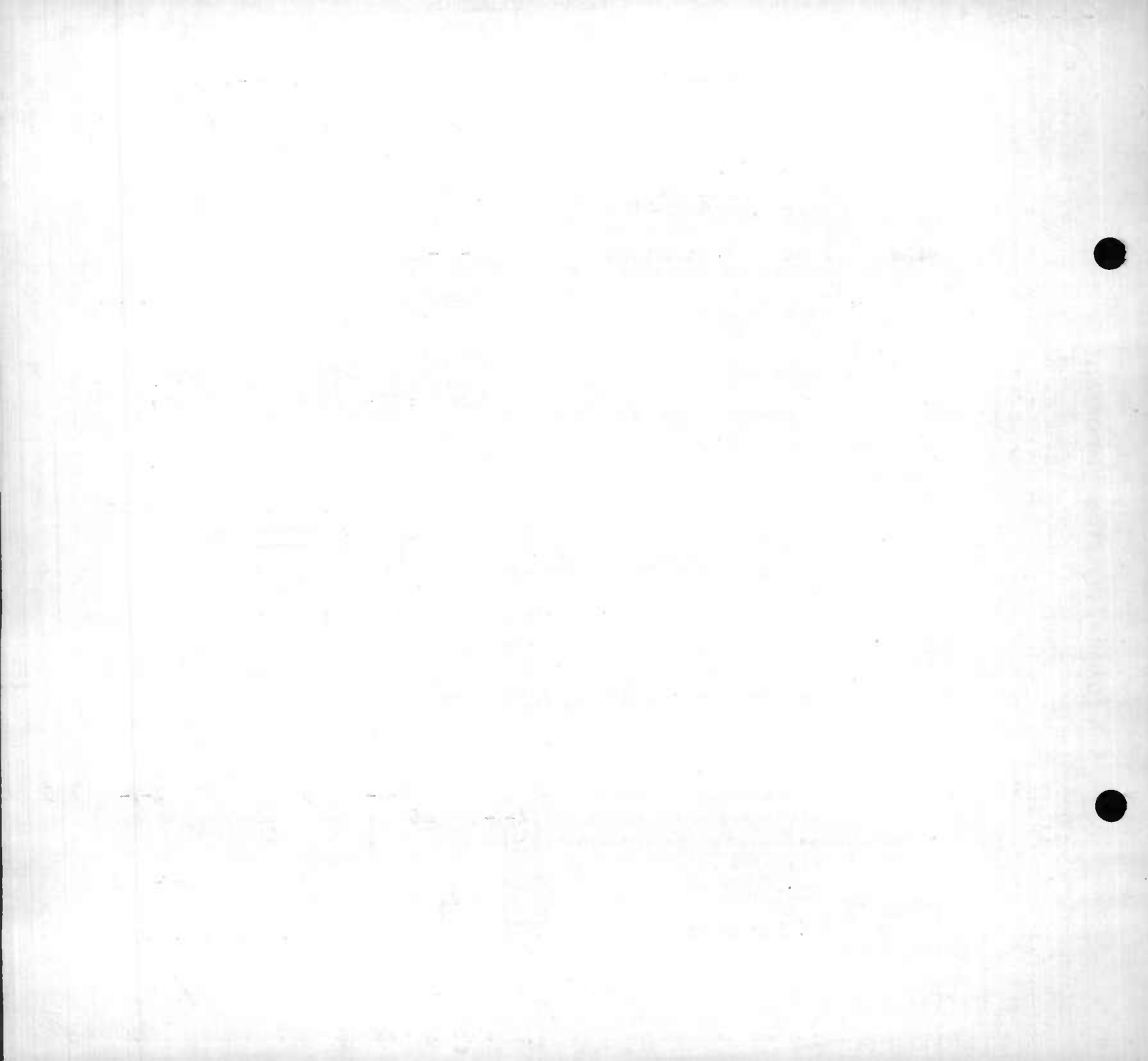
S. E. Schuster

ADDRESS

3615

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |   |  |  |   |  |  |  |  |
|---|------------------|---|--|--|---|--|--|--|--|
| BIRTH NO. 65 3800   |                  | CERTIFICATE OF DEATH  |  |  |   | Registered No. 65 3800   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) PAUL W. HERRMANN   |                  |   |  |  | 2. DATE AND HOUR OF DEATH<br>APRIL 2, 1965 11:50 P.M.   |  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>HOUSE-IN-THE-PINES NURSING HOME<br>2525 W. BELVEDERE AVENUE  |                  |   |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY TALBOT CO.<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>EASTON 20-00<br>D. STREET ADDRESS (If rural, give location) |  |  |  |  |
| 5. SEX<br>MALE  | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>WIDOWER                                       | 8. DATE OF BIRTH<br>SEPT. 8, 1873                  | 9. AGE (In years last birthday)<br>91                                    | If Under 1 Yr. Months Days  |  | If Under 24 Hrs. Hours Min.                |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>JEWELER - RET.   |                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>SELF EMPLOYED |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA        |  |  |
| 13. FATHER'S NAME<br>FREDERICK HERRMANN   |                  |   | 14. MOTHER'S MAIDEN NAME<br>BERTHA BORK            |  |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |  |  |
| 16. SOCIAL SECURITY NO.   |                  |   | 17. INFORMANT<br>FAMILY RECORDS                    |  |   | ADDRESS  |  |  |  |
| 18. 422.11<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |  |  | CAUSE OF DEATH<br>(A) Atherosclerotic cardio-vascular disease<br>DUE TO<br>(B) DUE TO<br>(C) DUE TO   |  | INTERVAL BETWEEN ONSET AND DEATH<br>10 yrs |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |   |  |  |   |  |  |  |  |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>no  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                     |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from July 1957 to Apr 2, 1965, that (I) (we) last saw the deceased alive on Apr 1, 1965, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                |                  |   |  |  |   |  |  |  |  |
| 23A. SIGNATURE<br>Frederick J. Vollmer<br>M.D.  |                  |   |  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |  | 23B. DATE SIGNED<br>Apr 4, 1965            |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>FREDERICK J. VOLLMER  |                  |   | 23D. ADDRESS<br>6100 York Rd.                      |  |   |  |  |  |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>REMOVAL/BURIAL   |                  | 24B. DATE<br>APRIL 5, 1965  |  | 24C. NAME OF CEMETERY or CREMATORY<br>SPRINGHILL CEMETERY                |   | 24D. LOCATION (City, town, or county) (State)<br>EASTON, TALBOT CO., MD.                                 |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965   |                  | 25B. NAME OF REGISTRAR<br>John B. Smith   |  | 25C. FUNERAL DIRECTOR<br>John B. Smith, Towson, Md.                      |   |  |  |  |  |

THE  
CITY OF  
NEW YORK

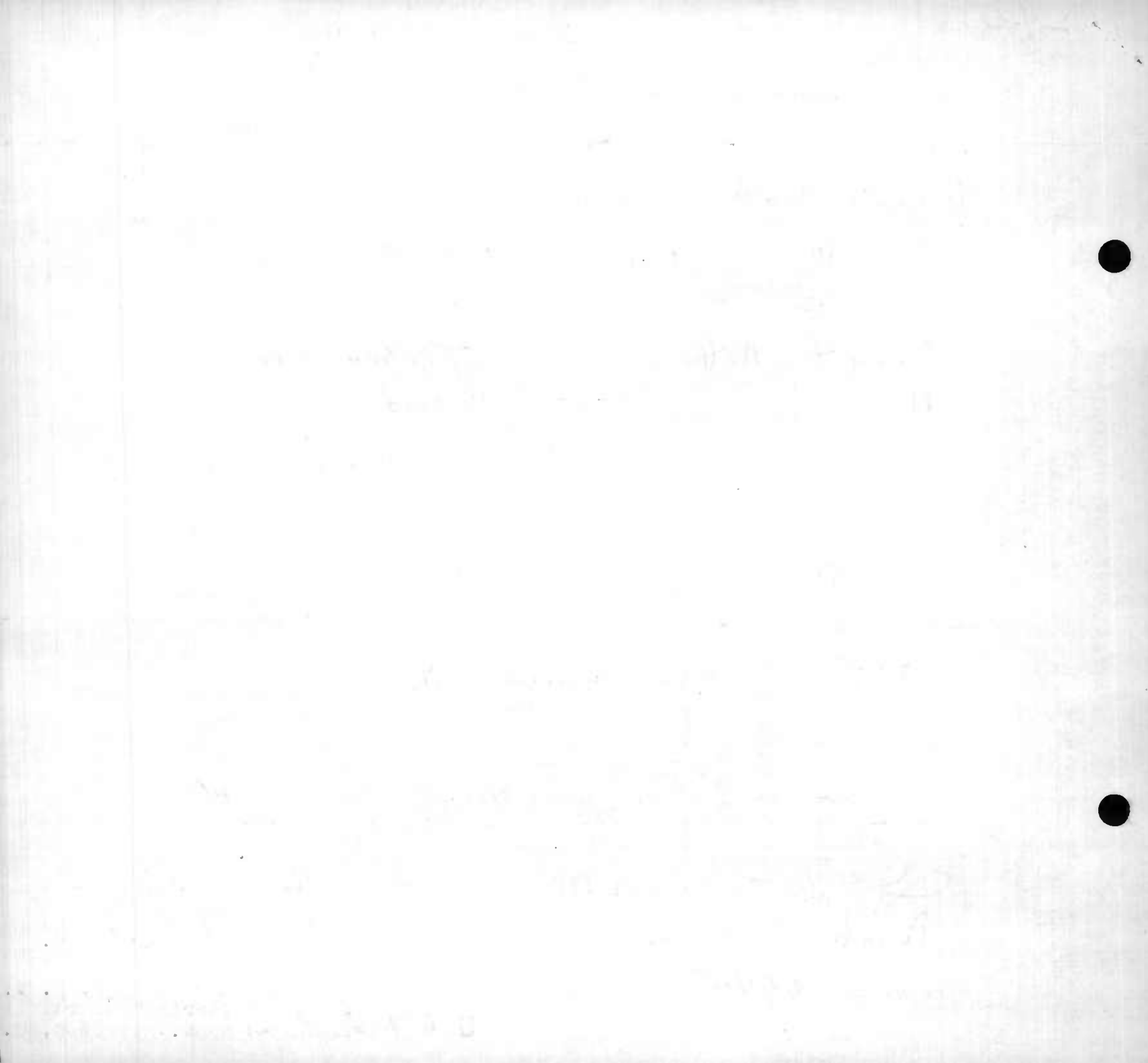
IN SENATE  
JANUARY 12, 1902  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE

ALBANY: J.B. LIPPINCOTT & CO. PRINTERS.  
1902.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3801   |              |   |   | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3801   |                 |
|---|--------------|---|---|--|--|--|-----------------|
| M.E. CASE NO.   |              |   |   | CERTIFICATE OF DEATH   |  |  |                 |
| 1. NAME OF DECEASED<br>(Type or Print) Beatrice Wykle   |              |   |   | 2. DATE AND HOUR OF DEATH<br>April 6, 1965 8 <sup>10</sup> A.M.                                  |  |  |                 |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |              |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)            |  |  |                 |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>University Hospital, Balto  |              |   |   | A. STATE Md. B. COUNTY Harford   |  |  |                 |
| (If not in hospital or institution, give street address or location)  |              |   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Aberdeen, Md. Box 108 |  |  |                 |
|   |              |   |   | D. STREET ADDRESS (If rural, give location)<br>62-00   |  |  |                 |
| 5. SEX<br>F   | 6. RACE<br>W | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>MARRIED                                       | 8. DATE OF BIRTH<br>10-25-25              | 9. AGE (In years lost birthday)<br>39  | 10. CITIZEN OF WHAT COUNTRY?<br>USA                        |  |                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |              |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home |  | 11. BIRTHPLACE (State or foreign country)<br>West Virginia |  |                 |
| 13. FATHER'S NAME<br>Emmett Arthur  |              |   | 14. MOTHER'S MAIDEN NAME<br>Thelma Kicks  |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA                        |  |                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |              |   | 16. SOCIAL SECURITY NO.<br>233-42-0974    |  | 17. INFORMANT<br>Husband                                   |  | ADDRESS<br>Same |
| 18. 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>Chronic Subdural Hematoma   |              |   |   | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO   |  |  |                 |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |              |   |   | INTERVAL BETWEEN ONSET AND DEATH<br>?  |  |  |                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |              |   |   |  |  |  |                 |
| 19A. DATE OF OPERATION<br>1/3/29/65   |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Subdural Hematoma                                     |   | 20A. AUTOPSY? (Yes or No)<br>No  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?           |                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                         |  |  |                 |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Nat While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |                 |
| 22. I certify that (this hospital) attended the deceased from 3/28/65 to 4/6/65, that (I) (we) lost the deceased alive on 4/6/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |              |   |   |  |  |  |                 |
| 23A. SIGNATURE<br>Donald T. Lewers  |              |   |   | 23B. DATE SIGNED<br>4/6/65   |  | 23C. PHYSICIAN'S NAME (Type)<br>DONALD T. LEWERS                               |                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Removal   |              | 24B. DATE<br>4/8/1965   |   | 24C. NAME OF CEMETERY or CREMATORY<br>Hillcrest Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>White Sulphur Springs, W. Va. |                 |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965   |              | 25B. NAME OF REGISTRAR<br>Beatrice Wykle  |   | 25C. FUNERAL DIRECTOR<br>Tarring Funeral Home, Aberdeen, Md.                                     |  | 25D. ADDRESS<br>Tarring Funeral Home, Aberdeen, Md.                            |                 |



1  
W 416

65 3802

BALTIMORE CITY HEALTH DEPARTMENT

65 3802

BIRTH NO. 65 3802

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) FLOYD B. WILBURN

2. DATE AND HOUR PRONOUNCED DEAD April 6, 1965 9:05 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE West Virginia B. COUNTY Berkeley

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Martinsburg

D. STREET ADDRESS (If rural, give location) Route 4

148 X Pike St X Street X

5. SEX Male 6. RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH January 12, 1913 9. AGE (In years last birthday) 52

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck driver

10B. KIND OF BUSINESS OR INDUSTRY Steel

11. BIRTHPLACE (State or foreign country) Martinsburg, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John William Wilburn

14. MOTHER'S MAIDEN NAME Daisy Bell Bowers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. No

17. INFORMANT ADDRESS Audra Baker Wilburn- Route 4, Martinsburg, W. Va.

18. CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH W. Va.

18A. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

18B. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) Arteriosclerotic cardiovascular disease

(B) DUE TO

(C) DUE TO

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 20A. AUTOPSY? (Yes or No) Yes

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21F. HOW DID INJURY OCCUR?

22. I certify that I held on Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE John E. Adams M.D. CHIEF MEDICAL EXAMINER

EXAMINER'S NAME (Type) John E. Adams, M.D. ASSISTANT MEDICAL EXAMINER

DATE SIGNED 4-6-65

23A. BURIAL CREMATION, REMOVAL (Specify) Burial

23B. DATE 4-9-65

23C. NAME OF CEMETERY or CREMATORY Rosedale Cemetery

23D. LOCATION (City, town, or county) (State) Martinsburg, Berkeley, W. Va.

24A. DATE REC'D BY HEALTH DEPT. APR 9 1965

24B. NAME OF REGISTRAR Robert E. Taylor M.D.

24C. FUNERAL DIRECTOR ADDRESS Howard K. Brown Brown Funeral Home-Martinsburg, W. Va.

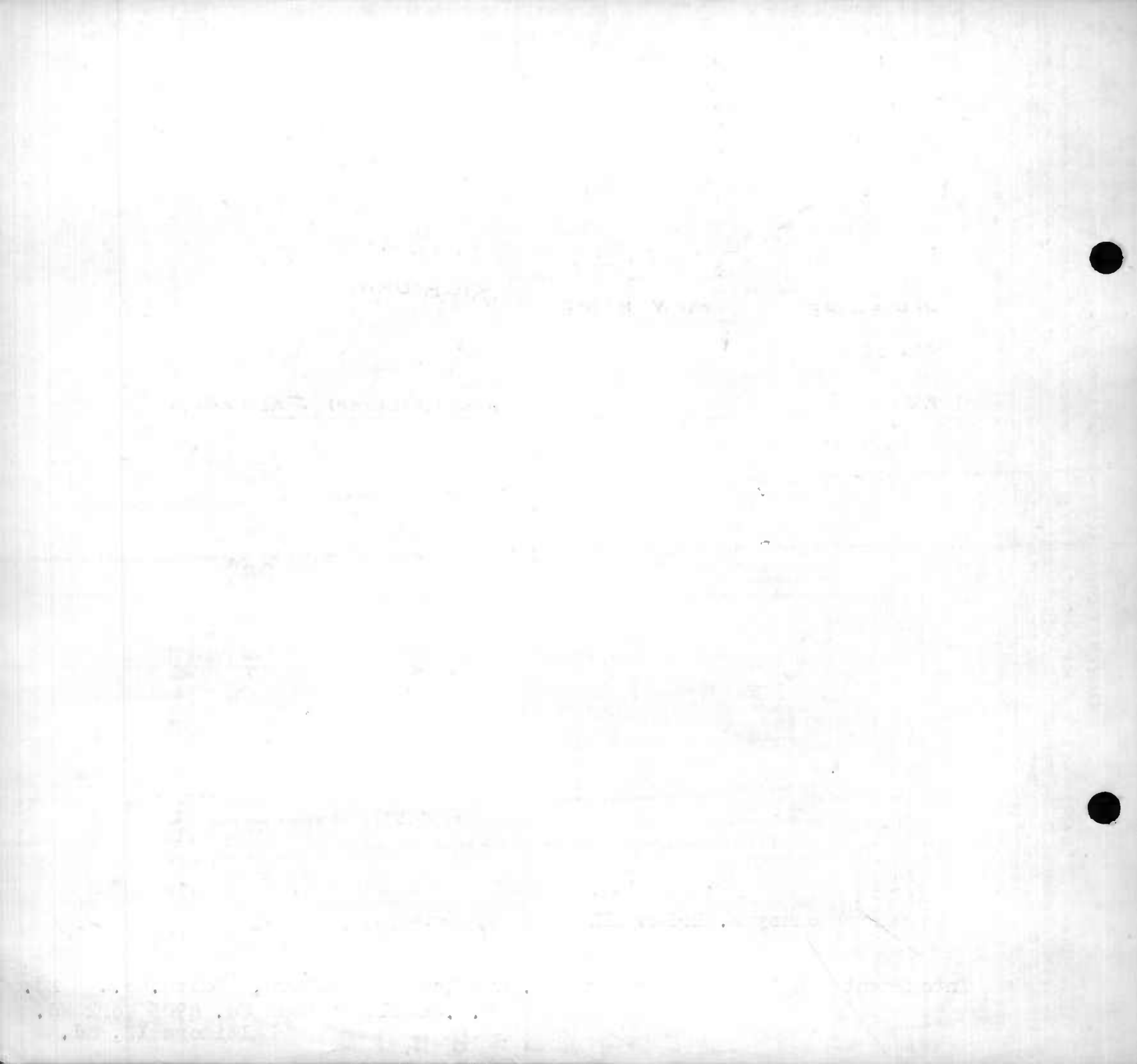
230

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3803  |                        |   |                                    | BALTIMORE CITY HEALTH DEPARTMENT  |                            | Registered No. 65 3803  |                             |
|--|------------------------|---|------------------------------------|---|----------------------------|---|-----------------------------|
| M.E. CASE NO.  |                        |   |                                    | CERTIFICATE OF DEATH  |                            |   |                             |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Lotta Loomis Michaels</i>  |                        |   |                                    | 2. DATE AND HOUR OF DEATH<br><i>4-8-65 4<sup>40</sup> P M.</i>  |                            |   |                             |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                        |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                            |   |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Union Memorial Hospital</i>   |                        | (If not in hospital or institution, give street address or location)                                      |                                    | A. STATE<br><i>Maryland</i>   |                            | B. COUNTY<br><i>Baltimore</i>   |                             |
|  |                        |   |                                    | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>                                     |                            |   |                             |
|  |                        |   |                                    | D. STREET ADDRESS (If rural, give location)<br><i>511 Broadview Apts. Balt 10</i>   |                            |   |                             |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>Can.</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Widowed</i>                                | 8. DATE OF BIRTH<br><i>3-31-79</i> | 9. AGE (In years lost birthday)<br><i>86</i>  | If Under 1 Yr. Months Days |   | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>HOUSEWIFE</i>  |                        | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>OWN HOME</i>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>KILBOURN, Wisconsin</i>   |                            | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |                             |
| 13. FATHER'S NAME<br><i>Carl Loomis</i>  |                        |   |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Caroline Kenealy</i>   |                            |   |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>  |                        | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><i>MRS. WILLIAM J. KENEALY</i>   |                            | ADDRESS<br><i>3900 N. CHARLES ST.</i>   |                             |
| 18. <i>4-20-1 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><i>Myocardial Infarction</i>  |                        |   |                                    | CAUSE OF DEATH  |                            | INTERVAL BETWEEN ONSET AND DEATH<br><i>5-10 minutes</i>                           |                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                        |   |                                    | (A) DUE TO<br><i>Coronary Thrombosis</i>  |                            | ?   |                             |
|  |                        |   |                                    | (B) DUE TO<br><i>Atherosclerotic Vascular Disease</i>   |                            |   |                             |
|  |                        |   |                                    | (C)   |                            |   |                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                        |   |                                    |   |                            |   |                             |
| 19A. DATE OF OPERATION<br><i>0</i>   |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                            |   |                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                        | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?  |                            |   |                             |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-4</i> 19 <i>65</i> to <i>4-8</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4-8</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                        |   |                                    |   |                            |   |                             |
| 23A. SIGNATURE<br><i>Rodney L. Briumhall</i> M.D.  |                        |   |                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                            | 23B. DATE SIGNED<br><i>4-8-65</i>   |                             |
| 23C. PHYSICIAN'S NAME (Type) <i>Rodney L. Briumhall</i>  |                        |   |                                    | 23D. ADDRESS<br><i>Union Memorial Hospital</i>  |                            |   |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Entombment</i>  |                        | 24B. DATE<br><i>4/10/1965</i>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><i>Lorraine Pk. Mausoleum</i>   |                            | 24D. LOCATION (City, town, or county) (State)<br><i>Woodlawn, Balto. Co., Md.</i> |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 9 1965</i>   |                        | 25B. NAME OF REGISTRAR<br><i>Robert E. Fisher</i>   |                                    | 25C. FUNERAL DIRECTOR<br><i>H.W. Jenkins &amp; Sons Co.</i>   |                            | ADDRESS<br><i>4905 York Rd. Baltimore 12, Md.</i>                                 |                             |







BIRTH NO. 65 3804 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3804

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JAMES O. HILL

2. DATE AND HOUR PRONOUNCED DEAD

April 3, 1965 7:25 p

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2104 Elsinore Avenue

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Divorced

8. DATE OF BIRTH

Oct. 23, 1905

9. AGE (In years  
last birthday)

59

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Shipyard

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Marlinton W. Va.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Richard W. Hill

14. MOTHER'S MAIDEN NAME

Anna Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Arlene Bowers Arborvale W. Va.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Gastro intestinal hemorrhage

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Erosion of esophagus

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?  
Yes21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-4-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/9/65

23C. NAME of CEMETERY or CREMATORY

Cockern Cemetery

23D. LOCATION (City, town, or county) (State)

Marlinton W. Va.

24A. DATE REC'D BY HEALTH DEPT.

APR 9

1965

24B. NAME OF REGISTRAR

Robert E. Fairbank

24C. FUNERAL DIRECTOR

Wm. Cook Brooks Funeral Home

ADDRESS

1217 St. Paul St. Balto. Md.

WALLACE SPENCER

1902, 1903, 1904

1905, 1906, 1907

1908, 1909, 1910

1911, 1912, 1913

1914, 1915, 1916

1917, 1918, 1919

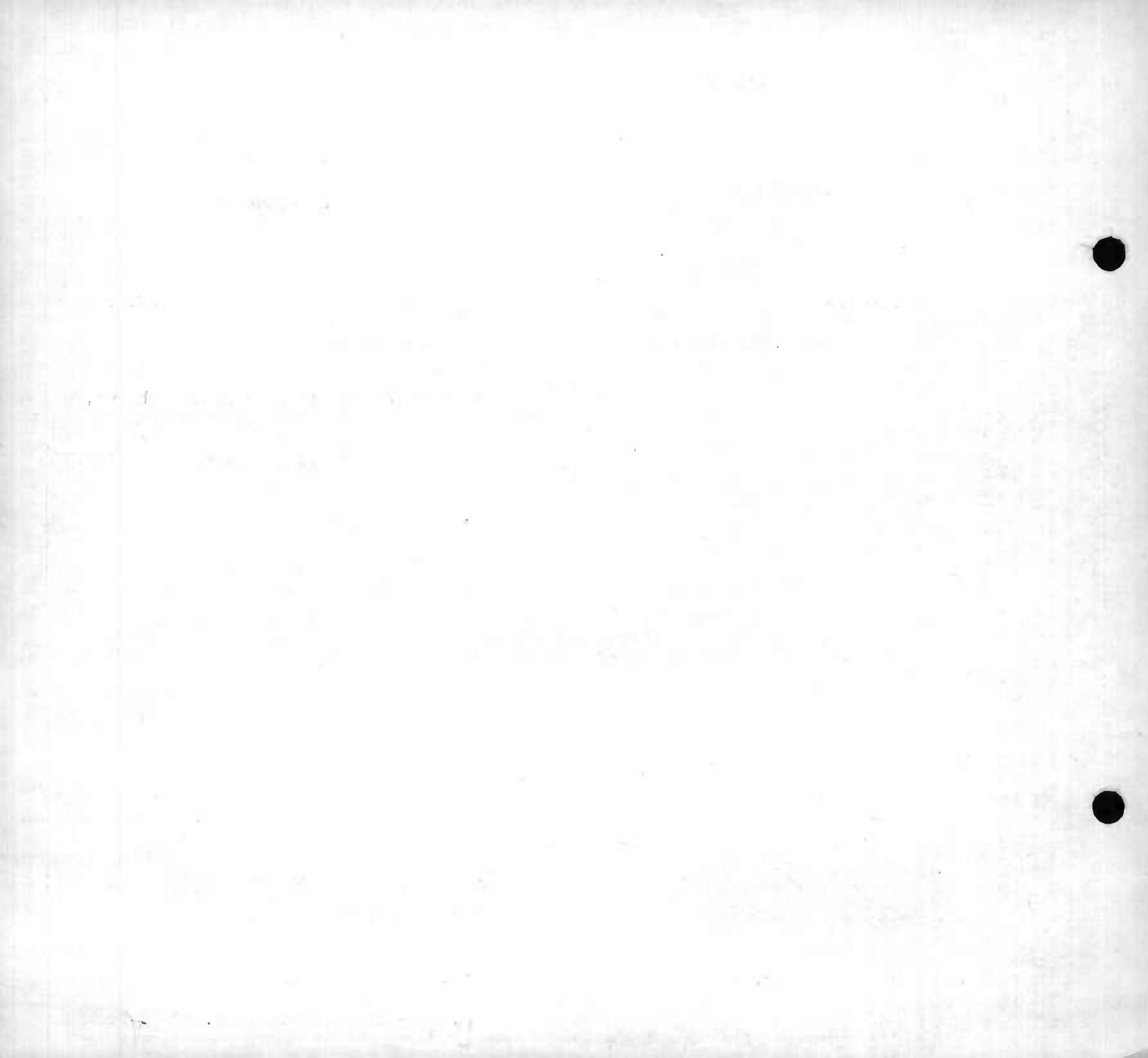
1920, 1921, 1922

1923, 1924, 1925

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

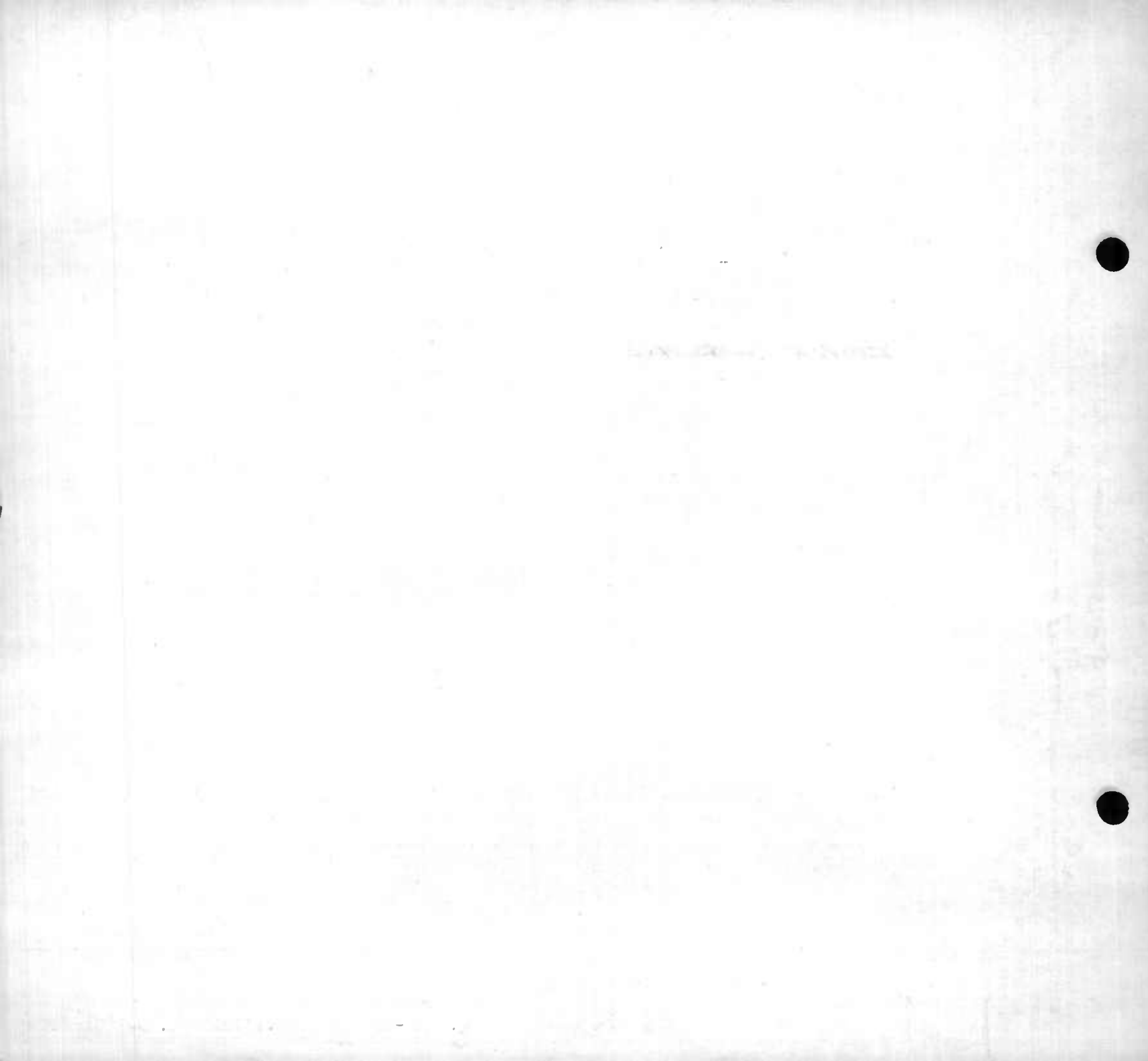
| BALTIMORE CITY HEALTH DEPARTMENT   |                             |   |   | Registered No. <b>65 3805</b>   |   |
|--|-----------------------------|---|---|---|---|
| BIRTH NO. <b>65 3805</b>   |                             | <b>CERTIFICATE OF DEATH</b>   |   |   |   |
| M.E. CASE NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <b>RUTH M. ANDERSON</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>4-6-65 905 P.M.</b>                           |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Mercy</b>  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 21204 (TOWSON) 5300</b><br>D. STREET ADDRESS (If rural, give location)<br><b>136 Marburth Avenue</b> |   |   |   |
| 5. SEX <b>F</b>  | 6. RACE <b>W</b>            | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>  | 8. DATE OF BIRTH<br><b>12-11-03</b>             | 9. AGE (In years last birthday)<br><b>61</b>                                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)<br><b>OHIO</b>                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>             |
| 13. FATHER'S NAME<br><b>Robert W. Hegfield</b>   |                             |   | 14. MOTHER'S MAIDEN NAME<br><b>Louise Wurst</b> |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                             | 16. SOCIAL SECURITY NO.<br><b>none</b>  |   | 17. INFORMANT<br><b>Herbert A. Anderson, 136 Marburth Ave, Towson</b>         |   |
| 18. <b>151X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.              |                             | CAUSE OF DEATH<br>(A) DUE TO <b>Gastric Carcinoma</b><br>(B) DUE TO<br>(C)  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 months</b>                           |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                             |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)      |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (A) (this hospital) attended the deceased from <b>MARCH 19 1965</b> to <b>April 6 1965</b> , that (I) <del>was</del> lost saw the deceased alive on <b>April 6 1965</b> and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>was</del> (did) (did not) view the body after death. |                             |   |   |   |   |
| 23A. SIGNATURE<br><b>D. Don K. edy</b>   |                             |   |   | 23B. DATE SIGNED<br><b>April 6 1965</b>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)   |                             | 23D. ADDRESS<br>M.D.  |   |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  | 24B. DATE<br><b>4-10-65</b> | 24C. NAME of CEMETERY or CREMATORY<br><b>Moreland Memorial Cemetery</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>             |   |
| 25A. DATE REC'D BY HEALTH DEPT.  |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Farkley</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Wm. Cook-Brooks, Towson, Inc., 1050 York Road</b> |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

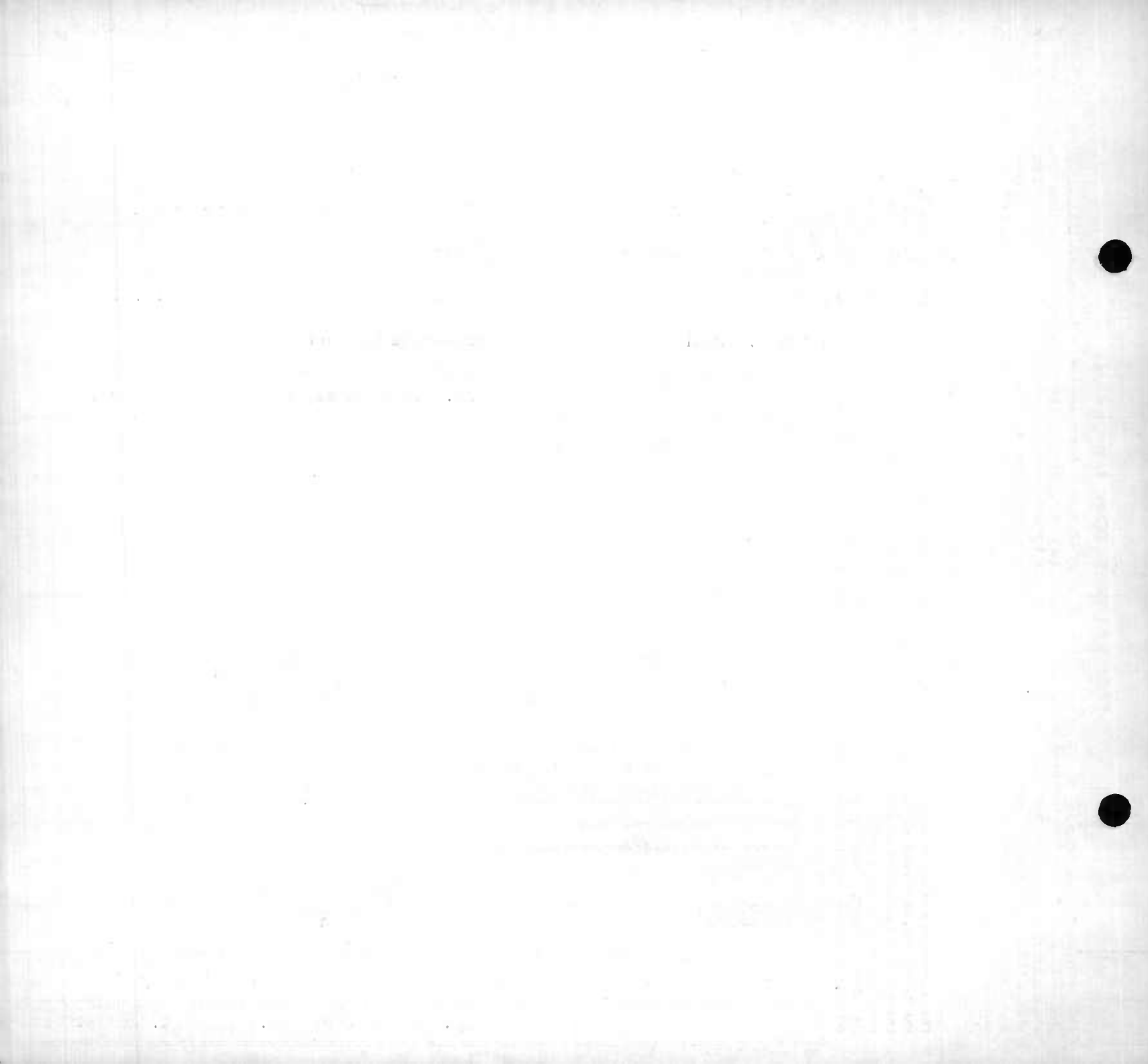
| BALTIMORE CITY HEALTH DEPARTMENT   |                     |  |                                    | Registered No. <span style="float: right;">65 3806</span>                           |   |
|--|---------------------|--|------------------------------------|---|---|
| BIRTH NO. <span style="float: right;">65 3806</span>   |                     | <b>CERTIFICATE OF DEATH</b>  |                                    |   |   |
| M.E. CASE NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>DEBORAH IRENE CLDFIELD</b>   |                                    | 2. DATE AND HOUR OF DEATH<br><b>APRIL 7 1965 4 P. M.</b>                            |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY       |                                    |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MONTEBELLO STATE HOSPITAL</b>   |                     | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE 21218</b>                                    |                                    |   |   |
|  |                     | D. STREET ADDRESS (If rural, give location)<br><b>3114 ABELL AVE. 12-02</b>  |                                    |   |   |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>   | 8. DATE OF BIRTH<br><b>5/27/97</b> | 9. AGE (In years lost birthday)<br><b>67</b>  | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CLERK</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>State of Maryland</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>NEW YORK</b>                        |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A</b>   |                     | 13. FATHER'S NAME<br><b>EDWARD S. KEATING</b>  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>PHOEBE KING</b>                                      |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                     | 16. SOCIAL SECURITY NO.<br><b>217-76-2802</b>  |                                    | 17. INFORMANT ADDRESS<br><b>HOSPITAL RECORDS - MONTEBELLO</b>                       |   |
| 18. <b>260X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) - stating the UNDERLYING CONDITION last. |                     | CAUSE OF DEATH<br>(A) <b>CEREBRAL THROMBOSES</b><br>DUE TO<br>(B) <b>DIABETES MELLITUS</b><br>DUE TO<br>(C)                          |                                    | INTERVAL BETWEEN ONSET AND DEATH  |   |
| <b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |  |                                    |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                     |  |                                    |   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)            |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |                                    | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>JAN. 20, 1965</b> to <b>APRIL 7, 1965</b> . that (I) (we) last saw the deceased alive on <b>APRIL 7, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                    |                     |  |                                    |   |   |
| 23A. SIGNATURE<br><b>Elmer R. Merani</b>   |                     | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                    | 23B. DATE SIGNED<br><b>April 7, 1965</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)   |                     | 23D. ADDRESS<br><b>Montebello State Hosp.</b>  |                                    |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                     | 24B. DATE<br><b>4-10-65</b>  |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Woodlawn Cemetery</b>                      |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Md</b>   |                     |  |                                    |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b>   |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b>  |                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Wm. Cook-Brooks, Inc., 1217 St. Paul Street</b> |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                      |  |  |  |  |
|---|----------------------|--|--|--|--|
| BIRTH NO. 65 3807   |                      | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3807   |  |
| M.E. CASE NO.   |                      |  | 1. NAME OF DECEASED (Type or Print) <i>William F. Smith</i>  |  |  |
| 2. DATE AND HOUR OF DEATH <i>4/7/65</i>   |                      |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MARYLAND</i><br>B. COUNTY <i>19-03</i>   |                      |  | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>   |  |  |
| 6. STREET ADDRESS (If rural, give location) <i>120 S. Calhoun Street</i>  |                      |  | 7. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Lincoln Memorial Nursing Home,<br/>27 N. Carey Street,<br/>BALTIMORE, MARYLAND, 21223</i> |  |  |
| 8. SEX <i>Male</i>  | 9. RACE <i>White</i> | 10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>Single</i>                                  | 11. DATE OF BIRTH <i>9/29/81</i>   | 12. AGE (In years last birthday) <i>83</i>                               | 13. If Under 1 Yr. Months: Days: Hours: Min. |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mill worker</i>  |                      | 14B. KIND OF BUSINESS OR INDUSTRY <i>B &amp; O</i>   |  | 15. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>           |  |
| 16. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>  |                      | 17. FATHER'S NAME <i>Julius H. Smith</i>   |  | 18. MOTHER'S MAIDEN NAME <i>Ernestine Gunlach</i>                        |  |
| 19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>  |                      | 20. SOCIAL SECURITY NO.  |  | 21. INFORMANT ADDRESS <i>Mrs. Clara McGee, 4903 Parkton Court,</i>       |  |
| 19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Arterio Sclerosis</i><br><i>Cardiovascular</i><br><i>Dislase</i><br><i>Blind</i>                               |                      |  | 20. INTERVAL BETWEEN ONSET AND DEATH <i>7</i>  |  |  |
| 21. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                      |  |  |  |  |
| 22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                      |  |  |  |  |
| 23A. DATE OF OPERATION <i>0</i>   |                      | 23B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 24A. AUTOPSY? (Yes or No)  |  |
| 25A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                      | 25B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 25C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 26A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                      | 26B. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 26C. HOW DID INJURY OCCUR?   |  |
| 27. I certify that (I) (this hospital) attended the deceased from <i>1-27-64</i> to <i>4-7-65</i> , that (I) (we) last saw the deceased alive on <i>4-6-64</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |  |  |  |  |
| 28A. SIGNATURE <i>Wm. E. Johnson</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |                      |  |  | 28B. DATE SIGNED <i>4/7-65</i>   |  |
| 29A. PHYSICIAN'S NAME (Type) <i>Wm. E. Johnson</i> M.D.   |                      |  |  | 29B. ADDRESS <i>4037 Neil Ave. 139</i>                                   |  |
| 30A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>  |                      | 30B. DATE <i>4-9-65</i>  |  | 30C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>            |  |
| 30D. LOCATION (City, town, or county) <i>5829 Ritchie Highway</i>   |                      | 30E. (State)   |  | 30F. DATE REC'D BY HEALTH DEPT. <i>APR 9 1965</i>                        |  |
| 30G. NAME OF REGISTRAR <i>Robert E. Taylor</i>  |                      | 30H. NAME OF REGISTRAR   |  | 30I. FUNERAL DIRECTOR <i>Wm. Cook-Brooks, Inc., 1217 St. Paul Street</i> |  |





BIRTH NO. 65 3808 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

|  |                         |   |  |
|--|-------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>HENRY LUKEN</b>   |                         | 2. DATE AND HOUR PRONOUNCED DEAD<br><b>April 7, 1965</b> <b>9:50 a</b> <b>M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>St. Joseph Hospital</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY _____<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1865 N. Gay St.</b> |  |
| 5. SEX<br><b>male</b>  | 6. RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Widower</b>  | 8. DATE OF BIRTH<br><b>Sept. 19, 1893</b>    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Handy Man</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Self Employed</b>   | 9. AGE (In years last birthday)<br><b>71</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore Maryland</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Herman Luken</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Barbara Huber</b>  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>212 14 1450</b>   |  |
| 17. INFORMANT<br><b>Mrs. Theresa Minnick</b>   |                         | ADDRESS<br><b>1865 Freedom Way</b>  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Bronchopneumonia</b><br>INTERVAL BETWEEN ONSET AND DEATH _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>Subdural hemorrhage</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>II<br>19A. DATE OF OPERATION<br><b>2</b><br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Yes</b><br>20A. AUTOPSY? (Yes or No)<br><b>Yes</b><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b><br>21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.<br><b>Street</b><br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>2200 E. North Avenue</b><br>21C. WHERE DID INJURY OCCUR?<br><b>08-02</b><br>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)<br><b>4 2 65 8:45</b><br>21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br><b>Apparently fell</b><br>22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Rudiger Breiteneker</b><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>4-7-65</b><br>23A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b><br>23B. DATE<br><b>4/10/65</b><br>23C. NAME OF CEMETERY or CREMATORY<br><b>Most Holy Redeemer</b><br>23D. LOCATION (City, town, or county) (State)<br><b>Baltimore Maryland</b><br>24A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b><br>24B. NAME OF REGISTRAR<br><b>Robert E. Farley</b><br>24C. FUNERAL DIRECTOR<br><b>Henry Sander &amp; Sons Inc.</b><br>ADDRESS<br><b>Baltimore Maryland 21213</b> |                         |   |  |

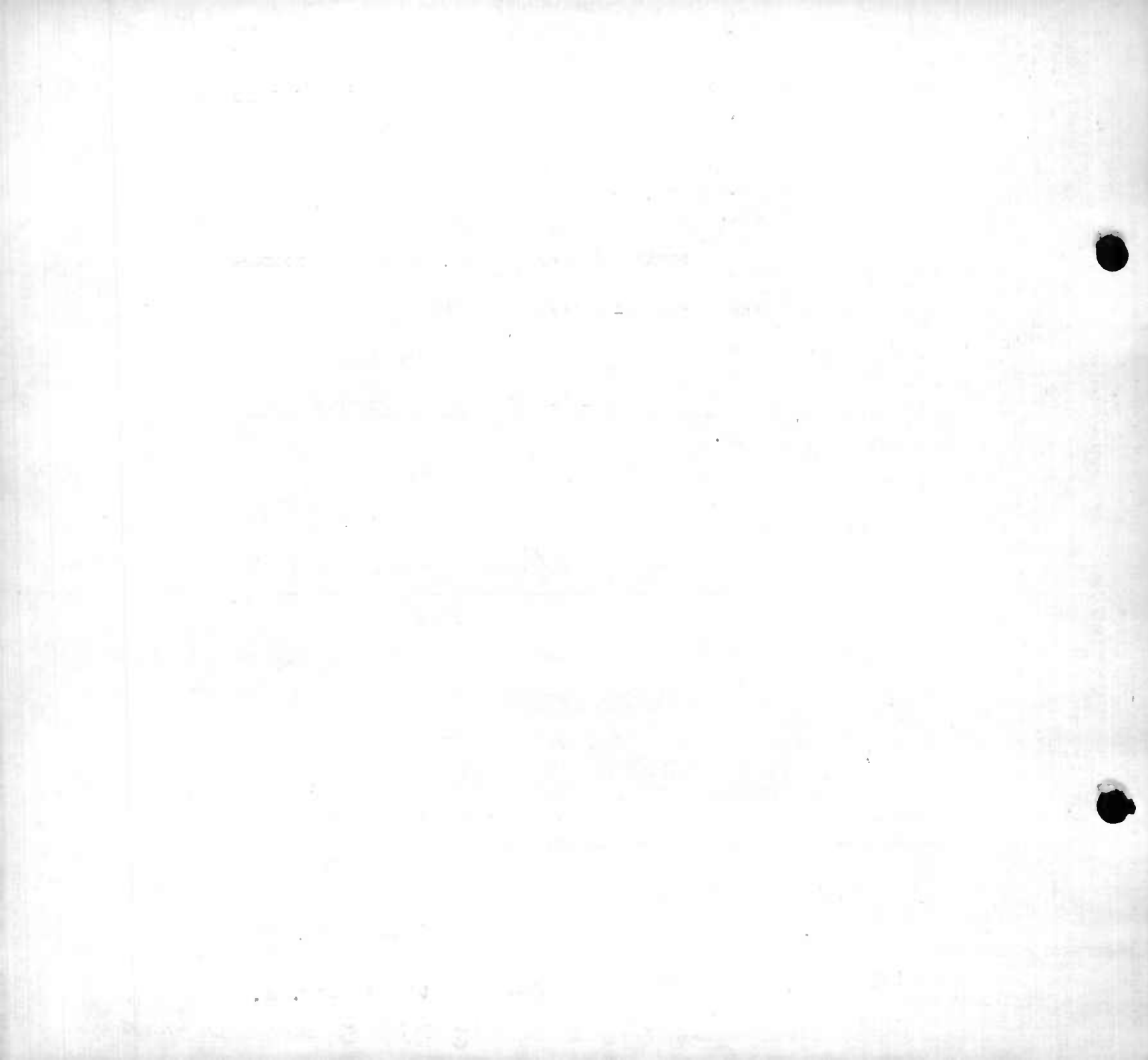
VALLEY POLICE

CRIMINAL

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |  |  |   |
|---|-------------------------|---|--|--|---|
| BIRTH NO. <b>4 65 3809</b>  |                         | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. <b>65 3809</b>  |   |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print)<br><b>SWEITZER, Edward Andrew</b>   |                         |   | 2. DATE AND HOUR OF DEATH<br><b>8:45 a.m. 4/8/65</b> <b>8:45 AM</b>  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JENKINS MEMORIAL HOSPITAL</b><br><b>1000 S Caton Ave.</b><br><b>Baltimore, Md. 21229</b>   |                         |   | 4. USUAL RESIDENCE (Where deceased lived - If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2804</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS N. (If rural, give location)<br><b>700 Cook's Lane</b> |  |   |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married Widower</b>                        | 8. DATE OF BIRTH<br><b>Nov. 10-1880</b>  | 9. AGE (In years last birthday)<br><b>x88x84</b>                         | If Under 1 Yr. Months: Days: Hours: Min.<br>If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Furniture Salesman</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Levenson &amp; Zenitz</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md</b>        |   |
| 13. FATHER'S NAME<br><b>Joseph Sweitzer</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Swann</b>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>214-01-6500</b>   |  | 17. INFORMANT<br><b>Medical Records Room</b>                             |   |
| 18. <b>331X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cerebral Vascular Accident</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Cerebral Arteriosclerosis</b><br><b>Generalized Arteriosclerosis</b> |                         |   | CAUSE OF DEATH<br>(A) <b>Cerebral Vascular Accident</b><br>DUE TO<br>(B) <b>Cerebral Arteriosclerosis</b><br>DUE TO<br>(C) <b>Generalized Arteriosclerosis</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b><br><b>years</b><br><b>years</b>  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (1) (this hospital) attended the deceased from <b>2/7 1962</b> to <b>April 8 1965</b> , that (2) (we) last saw the deceased alive on <b>4/8 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |  |  |   |
| 23A. SIGNATURE<br><b>J. Raymond Gladue</b><br>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                         |   |  | 23B. DATE SIGNED<br><b>4/8/65</b>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>J. RAYMOND GLADUE</b>  |                         |   |  | 23D. ADDRESS<br><b>3350 Wilkens Ave. 21229</b>                           |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                         | 24B. DATE<br><b>4/10/65</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>New Cathedral</b>               |   |
| 24D. LOCATION<br><b>Balto. Md.</b>  |                         | 24E. LOCATION (City, town, or county) (State)   |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>WITKIE FUNERAL HOME-4101 Edmondson</b>       |   |
| ADDRESS   |                         |   |  |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                      |  |   | 65 3810   |  |
|---|----------------------|--|---|---|--|
| BIRTH NO. 55 3810   |                      | CERTIFICATE OF DEATH   |   | Registered No. 65 3810  |  |
| M.E. CASE NO.   |                      | 1. NAME OF DECEASED (Type or Print) <b>Valenzia, Salvatore (Sam)</b>   |   | 2. DATE AND HOUR OF DEATH <b>4-7-65 5:55 A.M.</b>   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |   | 5. CITY OR TOWN (If outside city limits, write RURAL and give township)                                   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |                      | A. STATE <b>Baltimore</b> B. COUNTY <b>Maryland</b>  |   | C. CITY OR TOWN <b>Baltimore</b> (If outside city limits, write RURAL and give township)                  |  |
| 46 <b>Lutheran Hospital of Maryland.</b>  |                      | D. STREET ADDRESS (If rural, give location) <b>Baltimore 3503 Edmondson Ave</b>  |   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b> |  |
| 5. SEX <b>male</b>  | 6. RACE <b>white</b> | 7. MARRIED, NEVER MARRIED <b>Widowed</b>   | 8. DATE OF BIRTH <b>Sept. 11, 1892</b>    | 9. AGE (In years last birthday) <b>72</b>   | 11. BIRTHPLACE (State or foreign country) <b>Italy</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>Shoe repairs</b>  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b> |   |  |
| 13. FATHER'S NAME <b>-----Valenzia</b>  |                      | 14. MOTHER'S MAIDEN NAME <b>Unknown</b>  |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |
|   |                      | 16. SOCIAL SECURITY NO. <b>219 32 0866</b>   |   | 17. INFORMANT (daughter) <b>Mrs. Rosalie Pandolfini, 3503 Edmondson Ave</b>                               |  |
| 18. <b>4-34-11</b>  |                      | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |                      | (A) <b>congestive heart failure</b>  |   |   |  |
| (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  |                      | (B) <b>Heart Failure</b>   |   |   |  |
| ANTECEDENT CAUSES   |                      | (C)  |   |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      |  |   |   |  |
| II  |                      | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                       |   |   |  |
| 19A. DATE OF OPERATION  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) <b>No</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3-28-65</b> to <b>4-7-65</b> , that (I) (we) last saw the deceased alive on <b>4-5-65 5:45 AM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |  |   |   |  |
| 23A. SIGNATURE <b>S. Rajae</b>  |                      | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED <b>4/7/65</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>S. RAJAE</b>  |                      | M.D. 23D. ADDRESS  |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |                      | 24B. DATE <b>4/10/65</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>   |  |
| 24D. LOCATION (City, town, or county) <b>Balto. Md.</b>   |                      | 24E. LOCATION (State) <b>Balto. Md.</b>  |   |   |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>APR 9 1965</b>   |                      | 25B. NAME OF REGISTRAR <b>Robert E. Fairley</b>  |   | 25C. FUNERAL DIRECTOR ADDRESS <b>Witzke F.D. 4101 Edmondson Ave</b>                                       |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |  | 65 3811   |   |
|--|-------------------------|---|--|---|---|
| CERTIFICATE OF DEATH   |                         |   |  | Registered No. 65 3811  |   |
| BIRTH NO. 65 3811  |                         | M.E. CASE NO.   |  |   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Minnie F. Eiser</b>  |                         |   | 2. DATE AND HOUR OF DEATH<br><b>April 8/65</b>   <b>2:00 A.M.</b>  |   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>3901 Edmondson Ave.</b>  |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Ma.</b><br>B. COUNTY <b>20-07</b> |   |   |
|  |                         |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>  |   |   |
|  |                         |   | D. STREET ADDRESS (If rural, give location)<br><b>3901 Edmondson Ave</b>   |   |   |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>Feb. 3, 1888</b>  | 9. AGE (In years last birthday)<br><b>77</b>                                | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>H.W.</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>              |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                         |   |  |   |   |
| 13. FATHER'S NAME<br><b>John Grebe</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Minnie Hammerbacker</b>   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                         | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Elmer J. Eiser, 3901 Edmondson Ave</b>                  |   |
| 18. <b>199-2-1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.   |                         | CAUSE OF DEATH<br>(A) <b>abdominal Carcinomatosis</b><br>DUE TO <b>ascites</b><br>(B) <b>primary site undetermined</b><br>DUE TO<br>(C) <b>Arteriosclerotic Cardiac Vase. disease</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 wks. P.</b>                        |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |   |  |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>no</b>                                      |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                         |   |  |   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>June 3, 1956</b> to <b>April 8, 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Apr. 17, 1965</b> and that in (my) ( <del>an</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |                         |   |  |   |   |
| 23A. SIGNATURE<br><b>HARRY L. Knipp</b><br>M.D.  |                         |   | 23B. DATE SIGNED<br><b>4-9-65</b>  |   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>HARRY L. Knipp</b>  |                         |   | 23D. ADDRESS<br><b>4116 Edmondson Ave #29</b>  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4/10/65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park</b>                    |   |
| 24D. LOCATION<br><b>Baltimore Md</b>   |                         |   |  |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor M.D.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Witzke F.D. 4101 Edmondson Ave</b>              |   |



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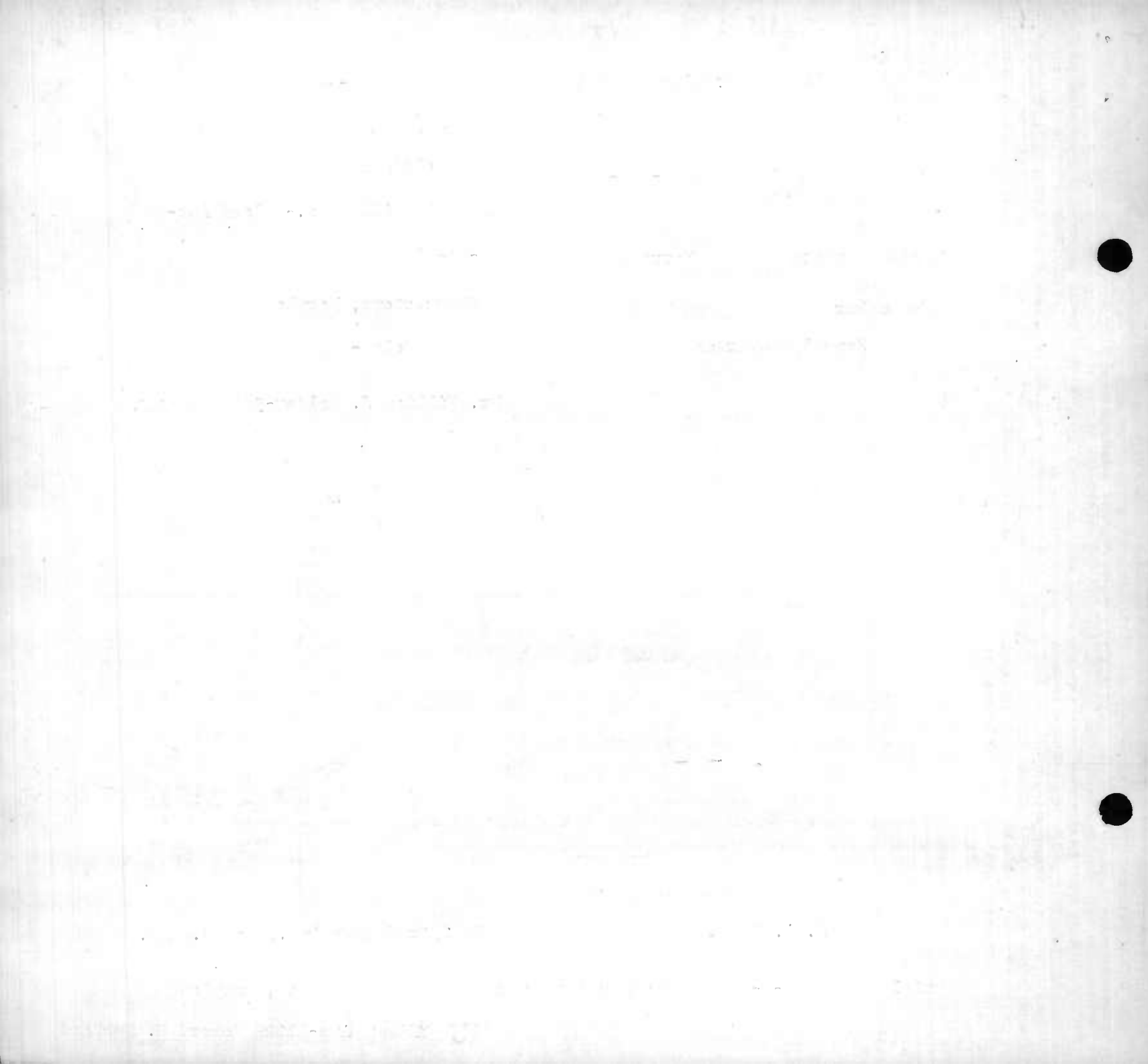
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                            |   |  |  |  |
|---|----------------------------|---|--|--|--|
| BIRTH NO. 65 3812   |                            | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |  | Registered No. 65 3812   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Blanche Estella Calder</b>   |                            |   | 2. DATE AND HOUR OF DEATH<br><b>4-5-65</b>   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>504 Glen Allen Drive-Apt-2B<br/>Upland Apts</b>   |                            |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>28-04</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>504 Glen Allen Dr.-Upland Apt-2B</b> |  |  |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>white</b>    | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>                                | 8. DATE OF BIRTH<br><b>12-25-84</b>  | 9. AGE (In years last birthday)<br><b>80</b>                                     | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                            | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Chestertown, Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?   |
| 13. FATHER'S NAME<br><b>Samuel Leaverton</b>  |                            |   | 14. MOTHER'S MAIDEN NAME<br><b>Nola -</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                            | 16. SOCIAL SECURITY NO.   | 17. INFORMANT ADDRESS<br><b>Mr. William J. Calder-504 Glen Allen Drive-29</b>  |  |  |
| 18. <b>420.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                            |   | CAUSE OF DEATH<br>(A) DUE TO<br><b>Coronary Thrombosis</b><br>(B) DUE TO<br><b>Revascularization (CVP)</b><br>(C)  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>instantly</b>                 |
| 19A. DATE OF OPERATION<br><b>0</b>  |                            | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                            | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)         |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                            | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1960</b> to <b>April 5 1965</b> , that (I) (we) last saw the deceased alive on <b>March 19 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                            |   |  |  |  |
| 23A. SIGNATURE<br><b>J. C. Pound</b>  |                            |   | 23B. DATE SIGNED   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>J. C. Pound</b>                   |
| 23D. ADDRESS<br><b>3325 Frederick Ave., Balto., Md.</b>   |                            |   | 23E. M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   | 24B. DATE<br><b>4-8-65</b> | 24C. NAME OF CEMETERY or CREMATORY<br><b>Meadowridge Memorial Park</b>                                    |  | 24D. LOCATION (City, town, or county) (State)<br><b>Elkridge, Maryland</b>       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b>  |                            | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>4107 Wilkens Ave-21229 Howard H. Hubbard</b> |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

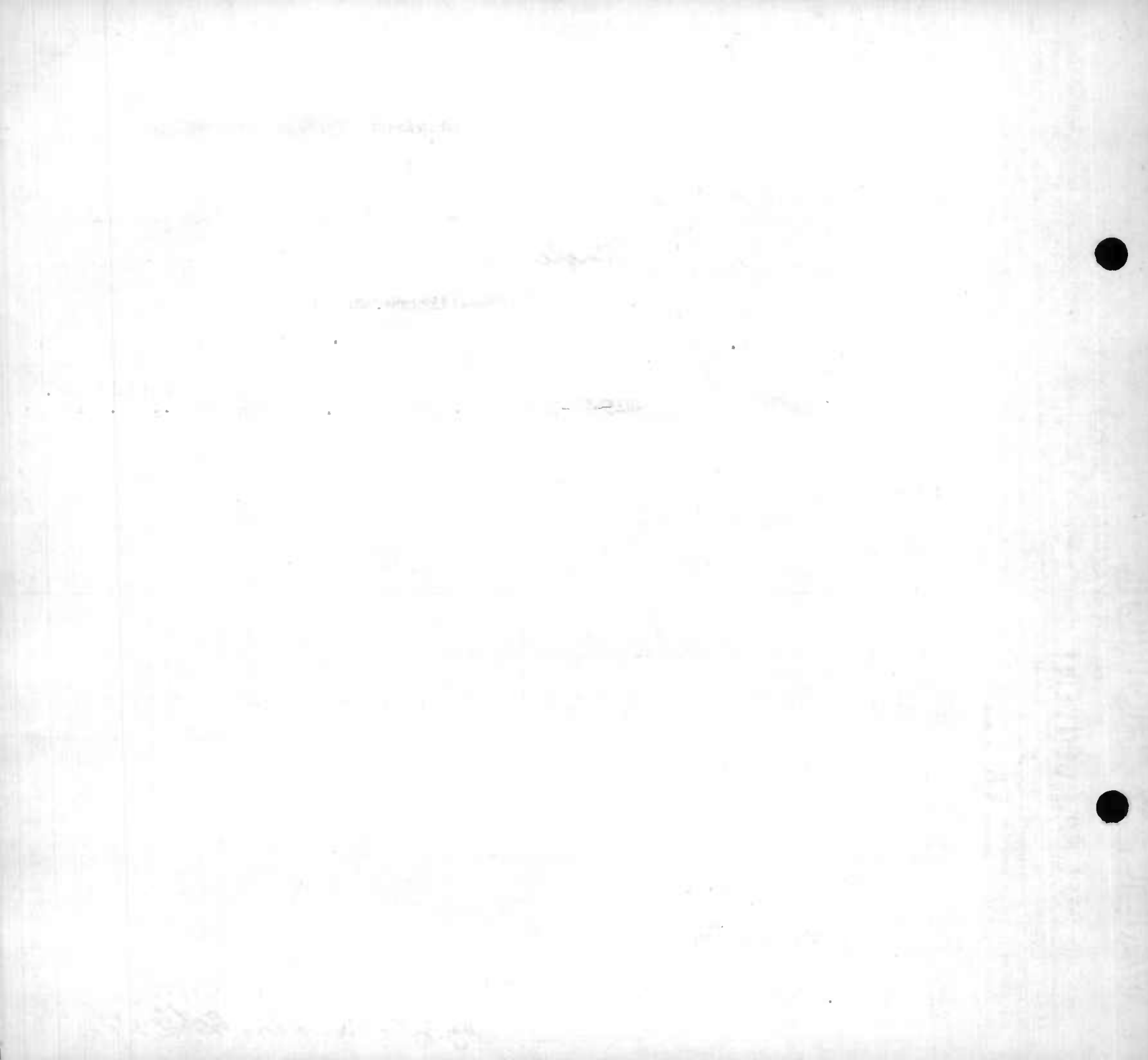
BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No.

65 3813

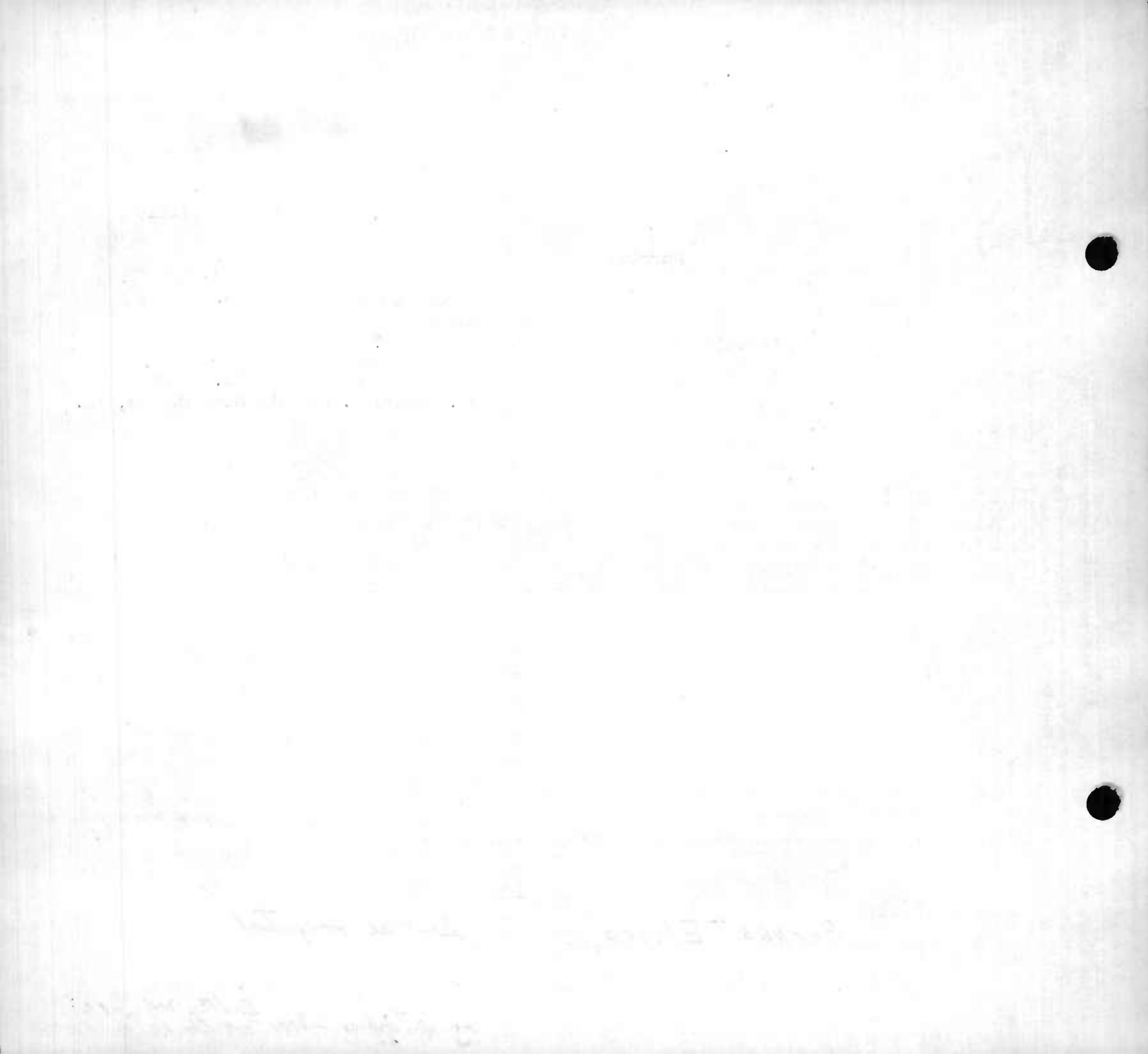
|  |                     |   |                                   |
|--|---------------------|---|-----------------------------------|
| BIRTH NO. 65 3813  |                     | M.E. CASE NO.   |                                   |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Dorothy Lucas</i>  |                     | 2. DATE AND HOUR OF DEATH<br><i>3 AM 4/9/65</i>   |                                   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Unmanned Hosp</i>  |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <i>Maryland</i><br>B. COUNTY <i>27109</i><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i><br>D. STREET ADDRESS (If rural, give location)<br><i>1639 East Cold Spring Lane 21218</i> |                                   |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>W</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Single</i>   | 8. DATE OF BIRTH<br><i>7/6/69</i> |
| 9. AGE (in years last birthday)<br><i>65</i>   |                     | 10. Under 1 Yr. Months: Days: Hours: Min.   |                                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Registered</i>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>edge</i>  |                                   |
| 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Maryland</i>  |                     | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |                                   |
| 13. FATHER'S NAME<br><i>Charles K. Lucas</i>   |                     | 14. MOTHER'S MAIDEN NAME<br><i>A. Alken</i>   |                                   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                     | 16. SOCIAL SECURITY NO.<br><i>215-24-7452</i>   |                                   |
| 17. INFORMANT<br><i>Mrs. Gertrude L. Johnson</i>   |                     | ADDRESS<br><i>3208 Ellerslie Ave. Balto., Md. 18</i>  |                                   |
| 18. <i>163X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>NONE</i> |                     | CAUSE OF DEATH<br>(A) <i>Carcinoma of lung</i><br>DUE TO<br>(B) _____<br>DUE TO<br>(C) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br><i>15 months</i>  |                                   |
| 19A. DATE OF OPERATION<br><i>NONE</i>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>NONE</i>   |                                   |
| 20A. AUTOPSY? (Yes or No)<br><i>NO</i>   |                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                     | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                                   |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                     | 21F. HOW DID INJURY OCCUR?  |                                   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/29</i> 19 <i>65</i> to <i>4/9</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4/9</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                     |   |                                   |
| 23A. SIGNATURE<br><i>Neil Robinson</i>   |                     | 23B. DATE SIGNED<br><i>4/9/65</i>   |                                   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Neil Robinson</i>   |                     | 23D. ADDRESS<br><i>M.D.</i>   |                                   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                     | 24B. DATE<br><i>4/12/1965</i>   |                                   |
| 24C. NAME OF CEMETERY or CREMATORY<br><i>Loudon Park Cemetery</i>  |                     | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>   |                                   |
| 25A. DATE RECEIVED BY HEALTH DEPT.<br><i>APR 9 1965</i>  |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Parker M.D.</i>  |                                   |
| 25C. FUNERAL DIRECTOR<br><i>Wm. J. Tishman &amp; Sons</i>  |                     | ADDRESS<br><i>Balto. Md. 21217</i>  |                                   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

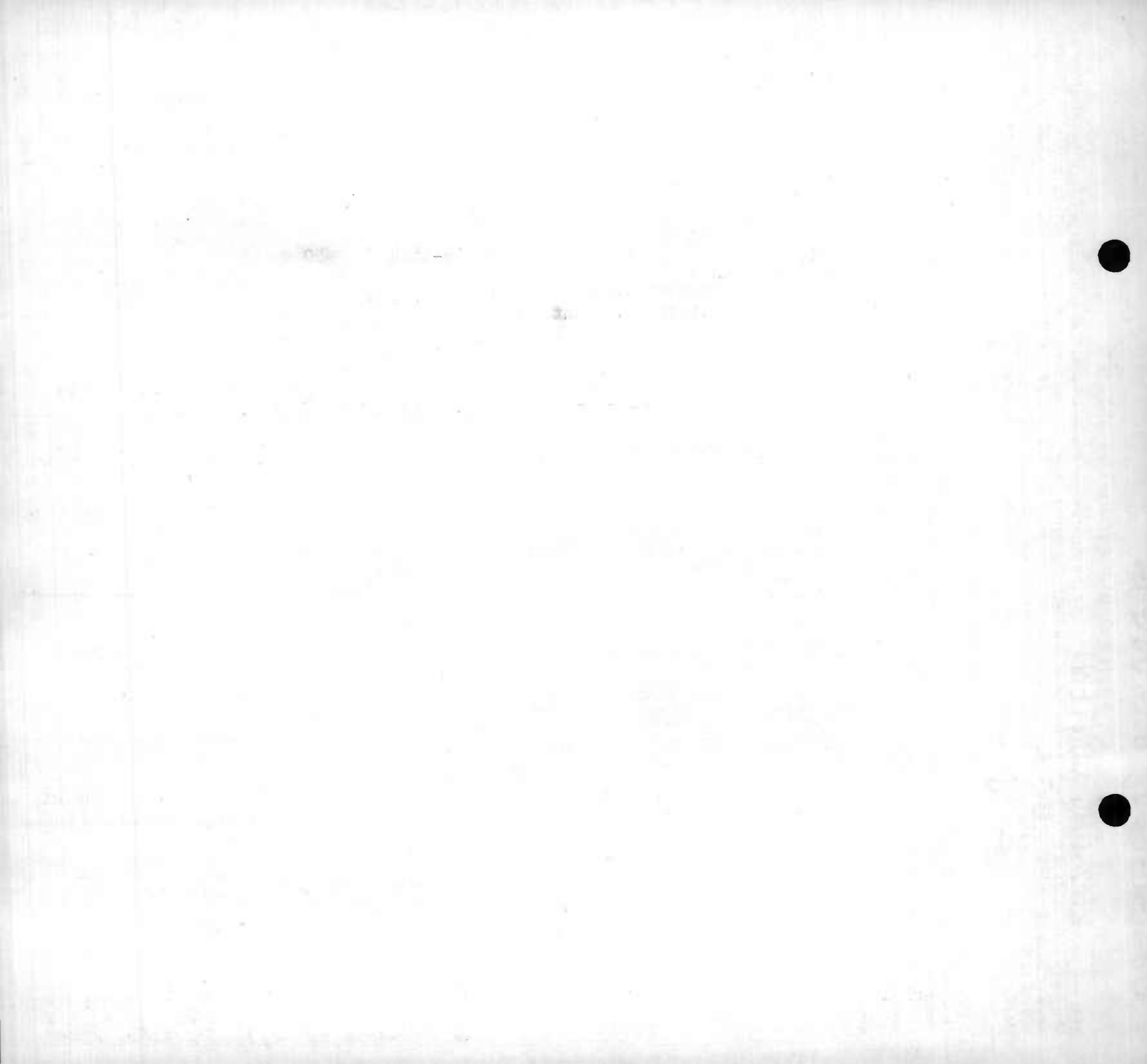
| BALTIMORE CITY HEALTH DEPARTMENT   |   |  |   | Registered No. <span style="font-size: 1.5em;">65 3814</span>                                     |   |
|--|---|--|---|---|---|
| BIRTH NO. <span style="font-size: 1.5em;">65 3814</span>   |   | <b>CERTIFICATE OF DEATH</b>  |   |   |   |
| M.E. CASE NO. 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">LEWIS D. STREWIG</span>   |   |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">April 8, 1965 4:20 A.M.</span>   |   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><span style="font-size: 1.2em;">Sinai Hospital of Baltimore, Inc.</span>  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">27-18</span>  |   |   |
|  |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.2em;">Baltimore</span>   |   |   |
|  |   |  | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.2em;">5102 Litchfield Ave. 21215</span>  |   |   |
| 5. SEX<br><span style="font-size: 1.2em;">M</span>   | 6. RACE<br><span style="font-size: 1.2em;">W</span> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.2em;">Married</span>           | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">3-1-01</span>   | 9. AGE (In years lost birthday)<br><span style="font-size: 1.2em;">64</span>                      | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Carpenter</span>  |   | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span> |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">? Strewig</span>  |   |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">?</span>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No None</span>   |   | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br><span style="font-size: 1.2em;">Rt. 2 Box 52 Mrs. Eloise L. Strewig Glen Burnie, Md.</span>  |   |   |
| 18. <span style="font-size: 1.5em;">322141913</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                     |   |  | CAUSE OF DEATH<br>(A) DUE TO <span style="font-size: 1.2em;">Hemorrhagic shock sec. to bleeding prepyloric ulcer</span><br>(B) DUE TO <span style="font-size: 1.2em;">Arteriosclerotic cardiovascular disease</span><br>(C) <span style="font-size: 1.2em;">chronic alcoholism</span> |   |   |
| INTERVAL BETWEEN ONSET AND DEATH   |   |  |   |   |   |
| II   |   |  |   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><span style="font-size: 1.2em;">Basal cell CA of forehead</span>   |   |  |   |   |   |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">1 4-3-65</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><span style="font-size: 1.2em;">Bleeding prepyloric ulcer</span> |   | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                          |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>               |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">4-3-1965</span> to <span style="font-size: 1.2em;">4-8-1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 8 1965</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |   |   |   |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Bernos Elvero</span> M.D.  |   |  |   | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">4-8-65</span>                                 |   |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Bernos Elvero</span> M.D.  |   |  |   | 23D. ADDRESS<br><span style="font-size: 1.2em;">Sinai Hospital</span>                             |   |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>   |   | 24B. DATE<br><span style="font-size: 1.2em;">4/10/1965</span>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Druid Ridge Cemetery</span> |   |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Pikesville, Maryland</span>   |   |  |   |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">APR 9 1965</span>   |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">G. E. Taylor</span>  |   | 25C. FUNERAL DIRECTOR ADDRESS<br><span style="font-size: 1.2em;">Baltimore, Md. 21217</span>      |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                    |   |                            | Registered No. — 65 3815   |   |
|--|--------------------|---|----------------------------|--|---|
| BIRTH NO. 65 3815  |                    | <b>CERTIFICATE OF DEATH</b>   |                            | DATE AND HOUR OF DEATH 4-6-65 7:45 P.M.  |   |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) FRANK T. ELLIS   |                    |   |                            |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore  |                            |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Union Memorial Hospital  |                    | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Towson 53-00  |                            |  |   |
|  |                    | D. STREET ADDRESS (If rural, give location) 921 Dulaney Valley Ct   |                            |  |   |
| 5. SEX Male  | 6. RACE White      | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married  | 8. DATE OF BIRTH 5-29-1884 | 9. AGE (In years last birthday) 80   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Executive  |                    | 10B. KIND OF BUSINESS OR INDUSTRY Thomsen Ellis Hutton Co. Printing   |                            | 11. BIRTHPLACE (State or foreign country) Nebraska                                     | 12. CITIZEN OF WHAT COUNTRY? USA                          |
| 13. FATHER'S NAME FRED ELLIS   |                    | 14. MOTHER'S MAIDEN NAME Margaret Ayers   |                            |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None   |                    | 16. SOCIAL SECURITY NO. 212-07-3607   |                            | 17. INFORMANT ADDRESS Mrs. Emma Ellis 921 Dulaney Valley Court Towson, Maryland        |   |
| 18. 443X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                    | CAUSE OF DEATH (A) Cerebral Vascular Accident. 3-4 days DUE TO (B) Hypertensive Cardio-Vascular disease DUE TO (C)              |                            | INTERVAL BETWEEN ONSET AND DEATH   |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                    |   |                            |  |   |
| 19A. DATE OF OPERATION 0   |                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                            | 20A. AUTOPSY? (Yes or No) NO   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)               |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                    | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                          |                            | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 4-4-65 to 4-6-65 1965, that (I) (we) last saw the deceased alive on 4-6-65 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                         |                    |   |                            |  |   |
| 23A. SIGNATURE Rodney L. Brimhall M.D.   |                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                            | 23B. DATE SIGNED 4-6-65  |   |
| 23C. PHYSICIAN'S NAME (Type) Rodney L. Brimhall M.D.   |                    | 23D. ADDRESS Union Memorial Hospital  |                            |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  | 24B. DATE 4/9/1965 | 24C. NAME of CEMETERY or CREMATORY Loudon Park Cemetery   |                            | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland                      |   |
| 25A. DATE REC'D BY HEALTH DEPT. APR 9 1965   |                    | 25B. NAME OF REGISTRAR Robert E. Johnson  |                            | 25C. FUNERAL DIRECTOR ADDRESS W.B. Johnson & Sons 21217 Balto., Md. north & Pa. avens. |   |

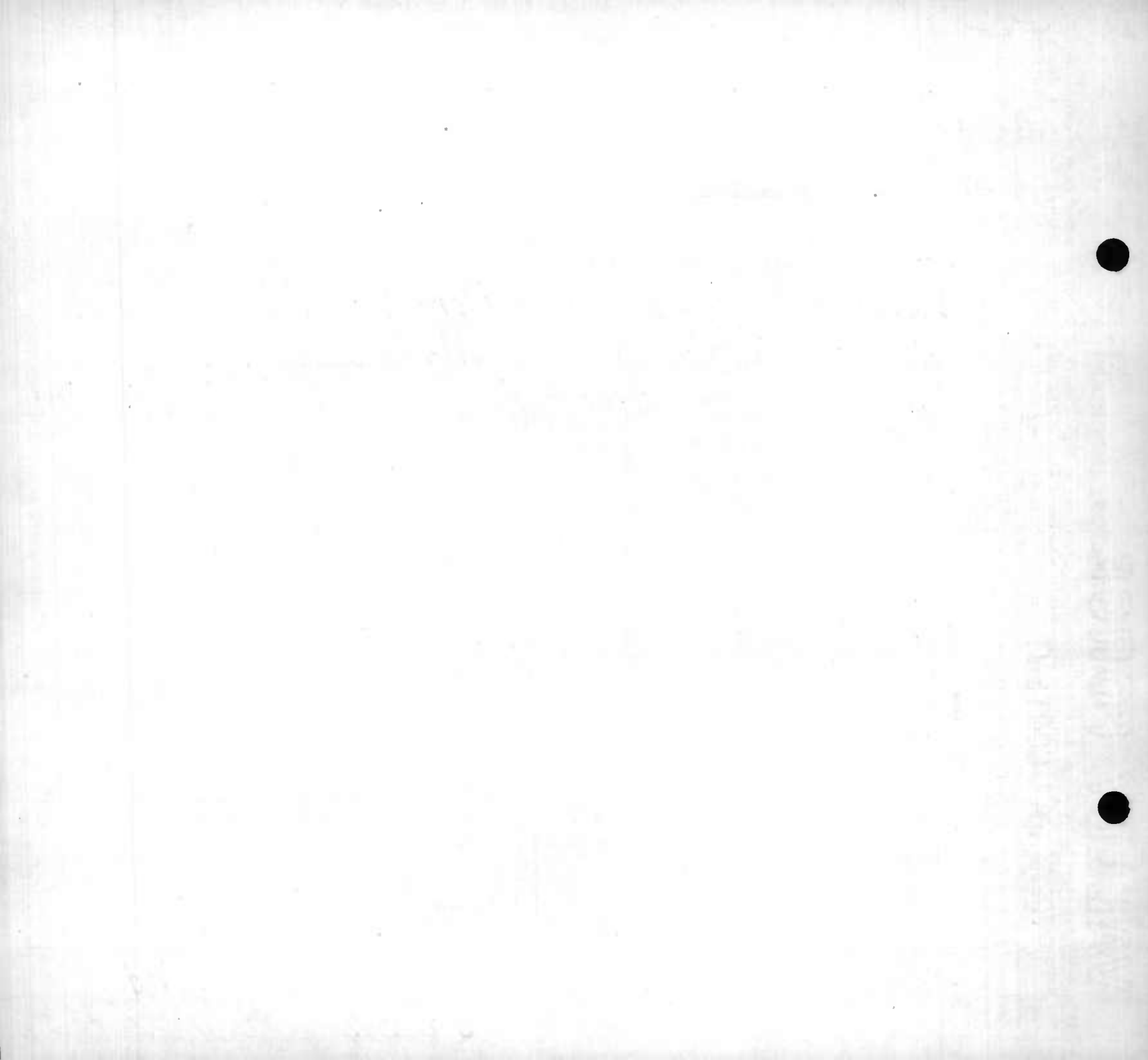




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

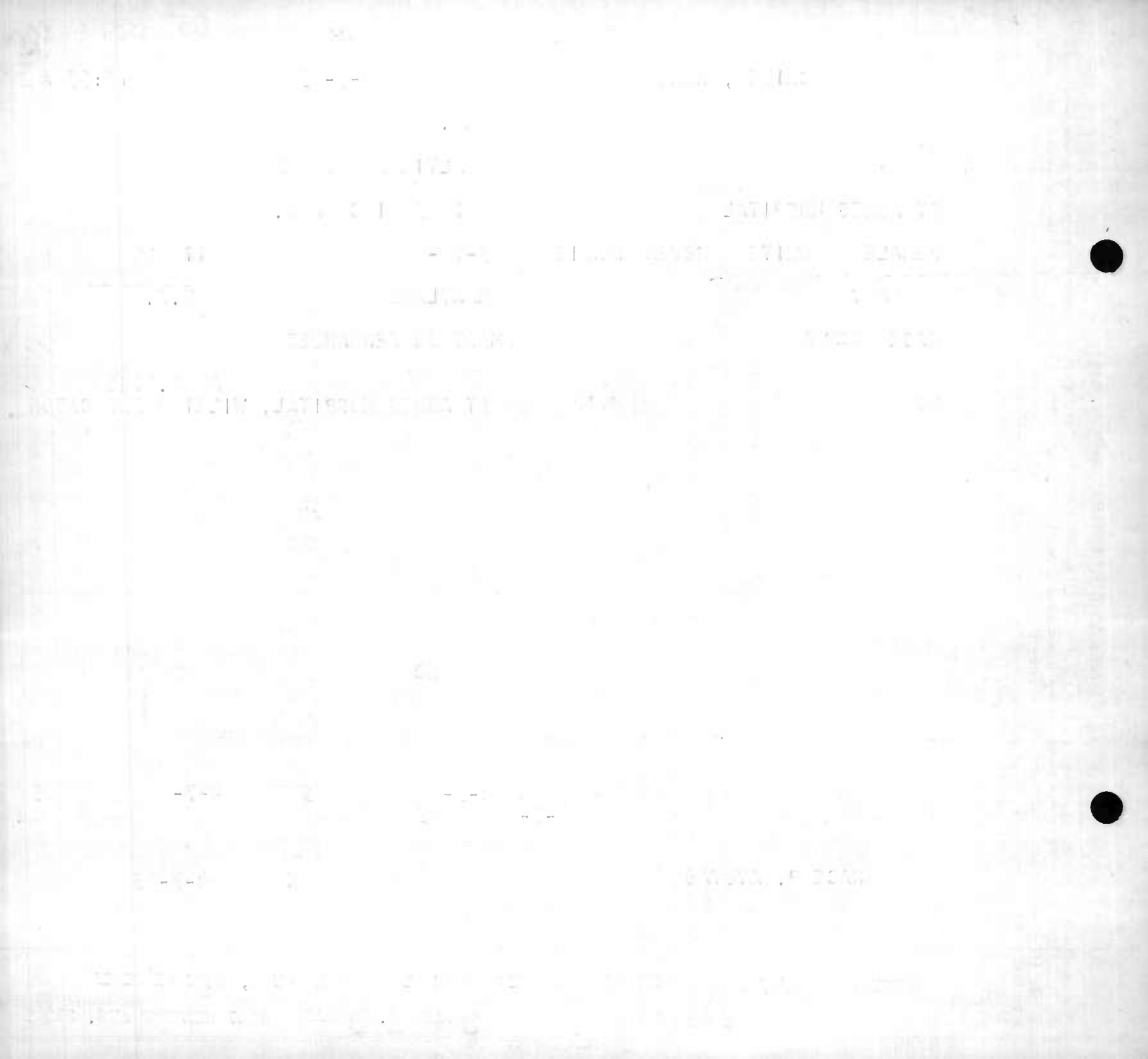
| BIRTH NO. 65 3816   |  |  |                  |  |  |  |  |  |                              | CERTIFICATE OF DEATH   |  |                                       |  |  |                            |  |  |                             |  | Registered No. 65 3816   |  |  |  |  |  |  |  |  |  |
|---|--|--|------------------|--|--|--|--|--|------------------------------|--|--|---------------------------------------|--|--|----------------------------|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|--|--|
| M.E. CASE NO.   |  |  |                  |  |  |  |  |  |                              | 1. NAME OF DECEASED<br>(Type or Print) McCULLOUGH, CARROLL N.  |  |                                       |  |  |                            |  |  |                             |  | 2. DATE AND HOUR OF DEATH<br>April 2, 1965 5:50 P. M.                                |  |  |  |  |  |  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |                  |  |  |  |  |  |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 9-08 |  |                                       |  |  |                            |  |  |                             |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore |  |  |  |  |  |  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>St. Joseph Hospital  |  |  |                  |  |  |  |  |  |                              | D. STREET ADDRESS (If rural, give location)<br>628 St. Ann Avenue  |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |
| 5. SEX<br>Male  |  |  | 6. RACE<br>White |  |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Divorced |  |  | 8. DATE OF BIRTH<br>11/19/03 |  |  | 9. AGE (In years last birthday)<br>61 |  |  | If Under 1 Yr. Months Days |  |  | If Under 24 Hrs. Hours Min. |  |  |  |  |  |  |  |  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer  |  |  |                  |  |  |  |  |  |                              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Drug  |  |                                       |  |  |                            |  |  |                             |  | 11. BIRTHPLACE (State, or foreign country)<br>Parkton, Md.                           |  |  |  |  |  |  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |                  |  |  |  |  |  |                              | 13. FATHER'S NAME<br>Charles McCullough  |  |                                       |  |  |                            |  |  |                             |  | 14. MOTHER'S MAIDEN NAME<br>Mary Zouck   |  |  |  |  |  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  |  |                  |  |  |  |  |  |                              | 16. SOCIAL SECURITY NO.<br>218-05-0528   |  |                                       |  |  |                            |  |  |                             |  | 17. INFORMANT<br>Mrs. Edna Ritzman, White Hall, Md.                                  |  |  |  |  |  |  |  |  |  |
| 18. 493X1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |                  |  |  |  |  |  |                              | CAUSE OF DEATH<br>(A) Severe Dehydration<br>DUE TO<br>(B) Gastro-enteritis<br>DUE TO<br>(C) Pneumonia                |  |                                       |  |  |                            |  |  |                             |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |                  |  |  |  |  |  |                              |  |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION<br>0   |  |  |                  |  |  |  |  |  |                              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |                                       |  |  |                            |  |  |                             |  | 20A. AUTOPSY? (Yes or No)<br>No  |  |  |  |  |  |  |  |  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |                  |  |  |  |  |  |                              |  |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  |  |                  |  |  |  |  |  |                              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |  |                                       |  |  |                            |  |  |                             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |  |  |  |  |  |  |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  |  |                  |  |  |  |  |  |                              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>            |  |                                       |  |  |                            |  |  |                             |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |  |  |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4/2/19 65 to 4/2/19 65, that (I) (we) last saw the deceased alive on 4/2/65 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                     |  |  |                  |  |  |  |  |  |                              |  |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |
| 23A. SIGNATURE<br>M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/><br>M.D. 4/3/65   |  |  |                  |  |  |  |  |  |                              | 23B. DATE SIGNED   |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>M.D. 1400 N. Caroline Street  |  |  |                  |  |  |  |  |  |                              | 23D. ADDRESS   |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  |  |                  |  |  |  |  |  |                              | 24B. DATE<br>4/5/65  |  |                                       |  |  |                            |  |  |                             |  | 24C. NAME of CEMETERY or CREMATORY<br>Middletown Cemetery                            |  |  |  |  |  |  |  |  |  |
| 24D. LOCATION (City, town, or county) (State)<br>Freeland, Md.  |  |  |                  |  |  |  |  |  |                              |  |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965   |  |  |                  |  |  |  |  |  |                              | 25B. NAME OF REGISTRAR<br>R. E. Taylor   |  |                                       |  |  |                            |  |  |                             |  | 25C. FUNERAL DIRECTOR<br>J. Jacoby   |  |  |  |  |  |  |  |  |  |
| 25D. ADDRESS<br>New Freedom, Pa.  |  |  |                  |  |  |  |  |  |                              |  |  |                                       |  |  |                            |  |  |                             |  |  |  |  |  |  |  |  |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

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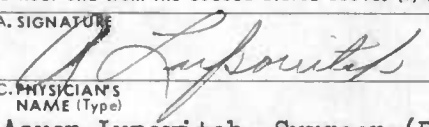
|   |  |  |  |   |  |
|---|--|--|--|---|--|
| BIRTH NO. <b>65 3817</b>  |  | BALTIMORE CITY HEALTH DEPT.  |  | REGISTERED NO. <b>65 3817</b>   |  |
| M.E. CASE NO.   |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH   |  |
| <b>CRITES, RENE</b>   |  | <b>4-7-65</b>  |  | <b>10:55 A.M.</b>   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                              |  | 5. CITY OR TOWN (If outside city limits, write RURAL and give township) |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST AGNES HOSPITAL</b>  |  | A. STATE<br><b>MD.</b>   |  | B. COUNTY<br><b>BALTIMORE</b>   |  |
| (If not in hospital or institution, give street address or location)  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |  | D. STREET ADDRESS (If rural, give location)                             |  |
| <b>BALTIMORE ARBUTUS</b>  |  | <b>1205 BIRCH AVE.</b>   |  | <b>BALTIMORE</b>  |  |
| 5. SEX<br><b>FEMALE</b>   |  | 6. RACE<br><b>WHITE</b>  |  | 7. MARRIED, NEVER MARRIED<br><b>NEVER MARRIED</b>                       |  |
| 8. DATE OF BIRTH<br><b>5-18-64</b>  |  | 9. AGE (In years last birthday)  |  | 10. CITIZEN OF WHAT COUNTRY?  |  |
| <b>10</b> Months <b>20</b> Days   |  | <b>10</b> Months <b>20</b> Days  |  | <b>U.S.</b>   |  |
| 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  | 13. FATHER'S NAME   |  |
| <b>MARYLAND</b>   |  | <b>U.S.</b>  |  | <b>JACK CRITES</b>  |  |
| 14. MOTHER'S MAIDEN NAME  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)           |  | 16. SOCIAL SECURITY NO.   |  |
| <b>MARY JO FERNANDEZ</b>  |  | <b>NO</b>  |  | <b>NONE</b>   |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH   |  | 19. ADDRESS   |  |
| <b>ST AGNES HOSPITAL, WILKINS AND CATON</b>   |  | <b>Acute Bronchopneumonia</b>  |  | <b>AVES. 24229</b>  |  |
| 20. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | 21. ANTECEDENT CAUSES  |  | 22. INTERVAL BETWEEN ONSET AND DEATH                                    |  |
| <b>Acute Bronchopneumonia</b>   |  | <b>Congenital Heart Disease</b>  |  | <b>Congestive Heart Failure</b>   |  |
| 23. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  | 25. MEDICAL CERTIFICATION   |  |
| <b>II</b>   |  | 26. DATE OF OPERATION  |  | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED                         |  |
| <b>19 65</b>  |  | <b>NO</b>  |  | 28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |
| 29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (initially medical examiner)                       |  | 30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                            |  | 31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 32. TIME OF INJURY (APPROX.)  |  | 33. INJURY OCCURRED  |  | 34. HOW DID INJURY OCCUR?   |  |
| <b>4-3-</b>   |  | <b>19 65</b>   |  | <b>4-7-</b>   |  |
| 35. I certify that (I) (this hospital) attended the deceased from   |  | 36. that (I) (we) last saw the deceased alive on   |  | 37. and that in (my) (our) opinion death occurred on the date           |  |
| <b>4-3-</b>   |  | <b>19 65</b>   |  | <b>4-7-</b>   |  |
| 38. and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.            |  | 39. SIGNATURE  |  | 40. DATE SIGNED   |  |
| <b>GRACE P. AYUYAO</b>  |  | <b>4-7-65</b>  |  | <b>4-7-65</b>   |  |
| 41. PHYSICIAN'S NAME (Type)   |  | 42. ADDRESS  |  | 43. DATE  |  |
| <b>Grace P. Ayuyao</b>  |  | <b>St. Agnes Hospital</b>  |  | <b>4-7-65</b>   |  |
| 44. BURIAL CREMATION, REMOVAL (Specify)   |  | 45. DATE   |  | 46. NAME of CEMETERY or CREMATORY                                       |  |
| <b>BURIAL</b>   |  | <b>4/9/65</b>  |  | <b>SHINNSTON MASONIC CEMETERY</b>                                       |  |
| 47. DATE REC'D BY HEALTH DEPT.  |  | 48. NAME of REGISTRAR  |  | 49. FUNERAL DIRECTOR  |  |
| <b>APR 9 1965</b>   |  | <b>HOWARD H. HUBBARD</b>   |  | <b>4107 WILKENS AVE. 21229</b>  |  |

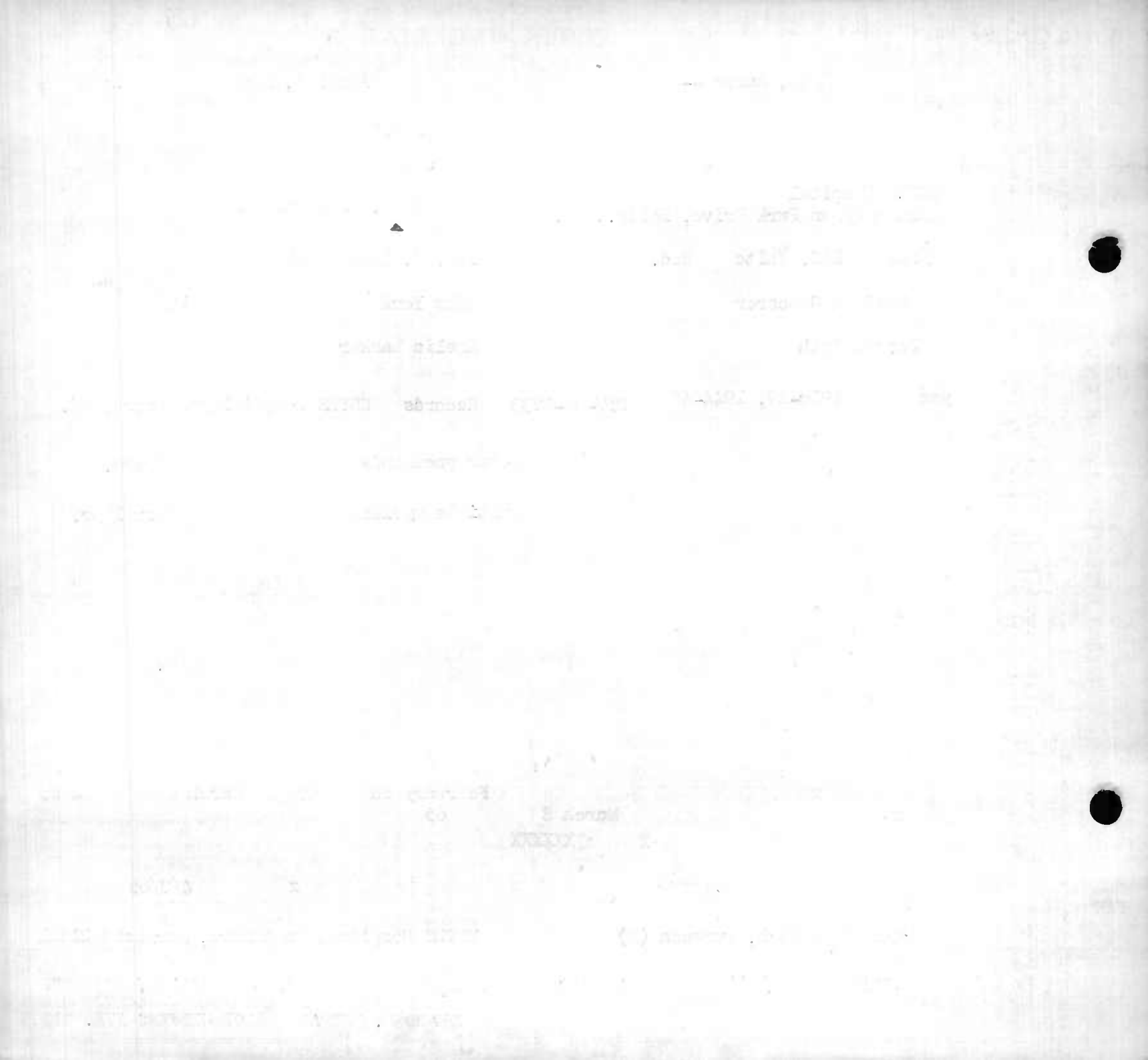


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

PAK

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| BIRTH NO. <b>65 3818</b>  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | 65 3818                                   |  |
| M.E. CASE NO.   |  | CERTIFICATE OF DEATH  |  | Registered No.                            |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |   |  |
| ROTH, Aaron --  |  | April 8, 1965   |  | 1:50 A.M.                                 |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>USPHS Hospital<br>31st & Wyman Park Drive, Balto., Md.  |  | A. STATE<br><br>VIRGINIA  |  | B. COUNTY<br><br>K-43                     |  |
|   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |   |  |
|   |  | Norfolk   |  |   |  |
|   |  | D. STREET ADDRESS (If rural, give location)   |  |   |  |
|   |  | 630 W. 34th Street  |  |   |  |
| 5. SEX  | 6. RACE  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)                              | 8. DATE OF BIRTH   | 9. AGE (In years last birthday)           | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male  | W.M. White   | Wid.  | Feb. 4, 1898   | 67  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country) |  |
| Retired Grocer  |  |   |  | New York                                  |  |
| 13. FATHER'S NAME   |  | 14. MOTHER'S MAIDEN NAME  |  | 12. CITIZEN OF WHAT COUNTRY?              |  |
| Joseph Roth   |  | Amelia Lasker   |  | USA                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS                     |  |
| yes   |  | 1918-19, 1944-45  |  | 057-07-7733                               |  |
|   |  |   |  | Records USPHS Hospital, Baltimore, Md.    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH          |  |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  |  | (A) DUE TO  |  | Lobar pneumonia                           |  |
| ANTECEDENT CAUSES   |  | (B) DUE TO  |  | Multiple myeloma                          |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.   |  | (C) _____   |  | Over 1 yr.                                |  |
| II  |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |   |  |
| 19A. DATE OF OPERATION  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| O   |  |   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |   |  |
|   |  |   |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |  |   |  |
|   |  |   |  |   |  |
| 22. I certify that (X) (this hospital) attended the deceased from February 18 19 65 to March 8 19 65, that (X) (we) lost saw the deceased alive on March 8 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE  |  |   |  | 23B. DATE SIGNED                          |  |
|    |  |   |  | 4/8/65                                    |  |
| 23C. PHYSICIAN'S NAME (Type)  |  | 23D. ADDRESS  |  |   |  |
| Aaron Lupovitch, Surgeon (R)  |  | USPHS Hospital, Baltimore, Maryland 21211   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  | 24B. DATE  | 24C. NAME OF CEMETERY or CREMATORY  | 24D. LOCATION (City, town, or county) (State)                        |   |  |
| BURIAL  | 4/1/65   | BETH DAVID CEMETERY   | ELMONT, LONG ISLAND, NEW YORK  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   | 25B. NAME OF REGISTRAR   | 25C. FUNERAL DIRECTOR ADDRESS   |  |   |  |
| APR 9 1965  |                     | HOWARD H. HUBBARD 4107 WILKENS AVE. 21229   |  |   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 65 3819

BIRTH NO. 65 3819

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

INEZ V. REED (Johnson)

2. DATE AND HOUR OF DEATH

4-8-65

4<sup>00</sup> A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

LUTHERAN HOSPITAL OF MARYLAND

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

BALTIMORE

D. STREET ADDRESS (If rural, give location)

1011 W. 42ND ST, #11

5. SEX

F

6. RACE

C

7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

3-17-19

9. AGE (In years last birthday)

46

If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Specialist in Dept. of Education

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Harvey R. Johnson

14. MOTHER'S MAIDEN NAME

Thiodosia Jenkins

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-20-8857

17. INFORMANT

Mr. Ernest E. Reed, 1011 W. 42nd Street

ADDRESS

18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) GENERALIZED METASTASIS DUE TO

(B) CARCINOMA OF BREAST DUE TO

(C)

INTERVAL BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-20-1965 to 4-8-1965, that (I) (we) last saw the deceased alive on 4-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Jesus G. Santiano

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4-8-65

23C. PHYSICIAN'S NAME (Type)

JESUS G. SANTIANO

M.D.

23D. ADDRESS

LUTHERAN HOSPITAL OF Md.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

3-12-65

24C. NAME of CEMETERY or CREMATORY

Baltimore National

24D. LOCATION

Baltimore Maryland

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT

APR 9 1965

25B. NAME OF REGISTRAR

Robert E. Webb

25C. FUNERAL DIRECTOR

Wilton Webb, 3613 Dennlyn Rd.

ADDRESS





BIRTH NO. 65 3820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3820

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EMMA E. HALL

2. DATE AND HOUR PRONOUNCED DEAD

4/8/65 13:20 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1903 Eutaw Place

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Aug 12, 1965

9. AGE (In years  
last birthday)

59

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF  
WHAT COUNTRY?  
U. S. A.

13. FATHER'S NAME

Frank Taylor

14. MOTHER'S MAIDEN NAME

Meteldia Brogden

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

17. INFORMANT

ADDRESS

Gladys Gibson 1911 Eutaw Pl.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

W. U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/9/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-11-65

23C. NAME of CEMETERY or CREMATORY

St Stevens Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 9 1965

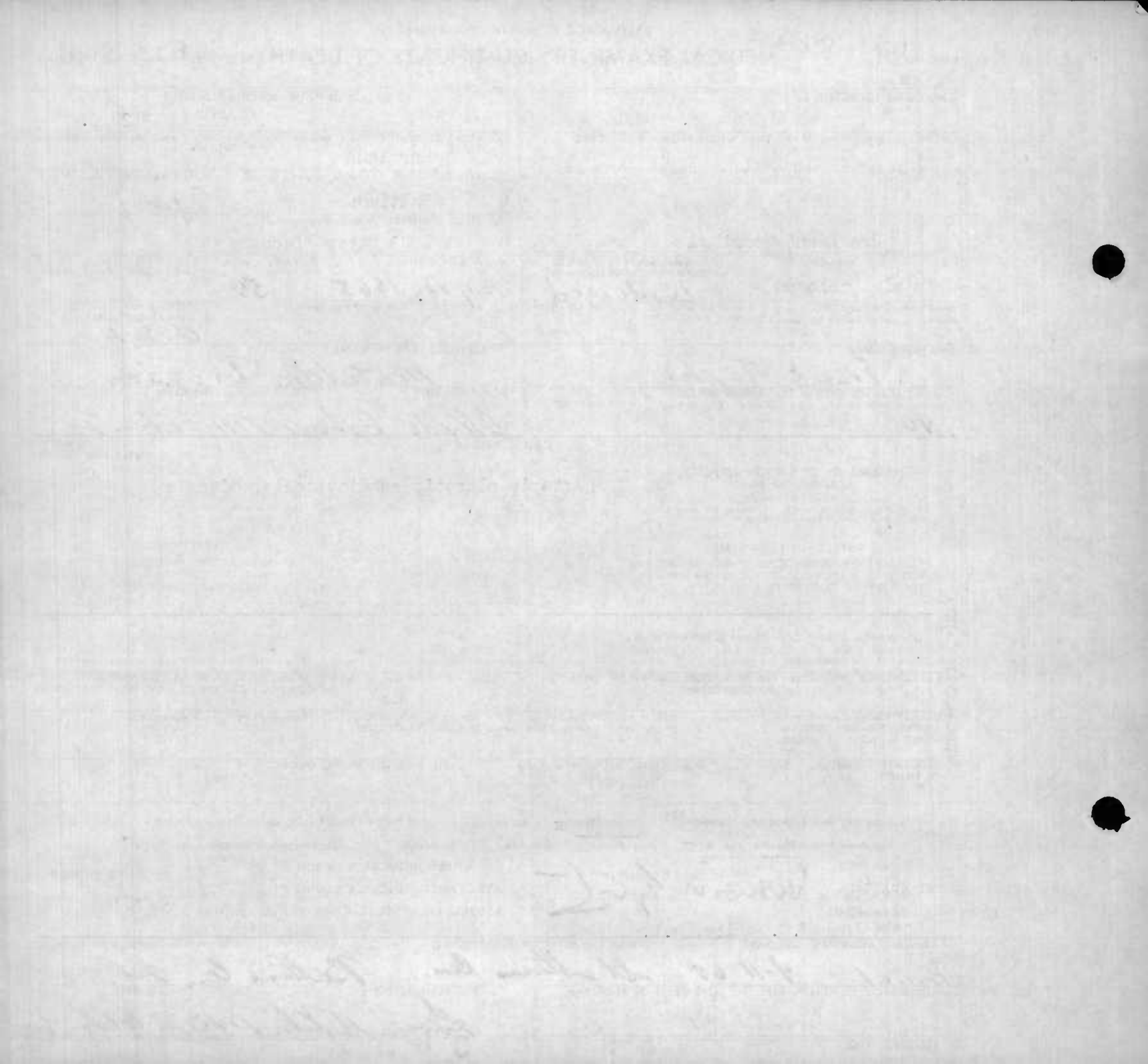
24B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

24C. FUNERAL DIRECTOR

Gladys Gibson 1548 N. Calhoun St

ADDRESS



## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. 65 3821 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3821

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

BETTY PORTER

2. DATE AND HOUR PRONOUNCED DEAD

April 7, 1965 10:00 P M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1111 N. Calhoun Street

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

11/22/1900

9. AGE (In years  
last birthday)

64

If Under 1 Yr. II Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

OBEY OLDS

14. MOTHER'S MAIDEN NAME

FLORENCE JAMES

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Nathan Porter 1111 N. Calhoun St

1B.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Hypertensive Cardiovascular Disease.  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT ☐ NOT WHILE  
WORK AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/8/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/12/65

23C. NAME OF CEMETERY or CREMATORY

Mt Auburn Cem.

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 9 1965

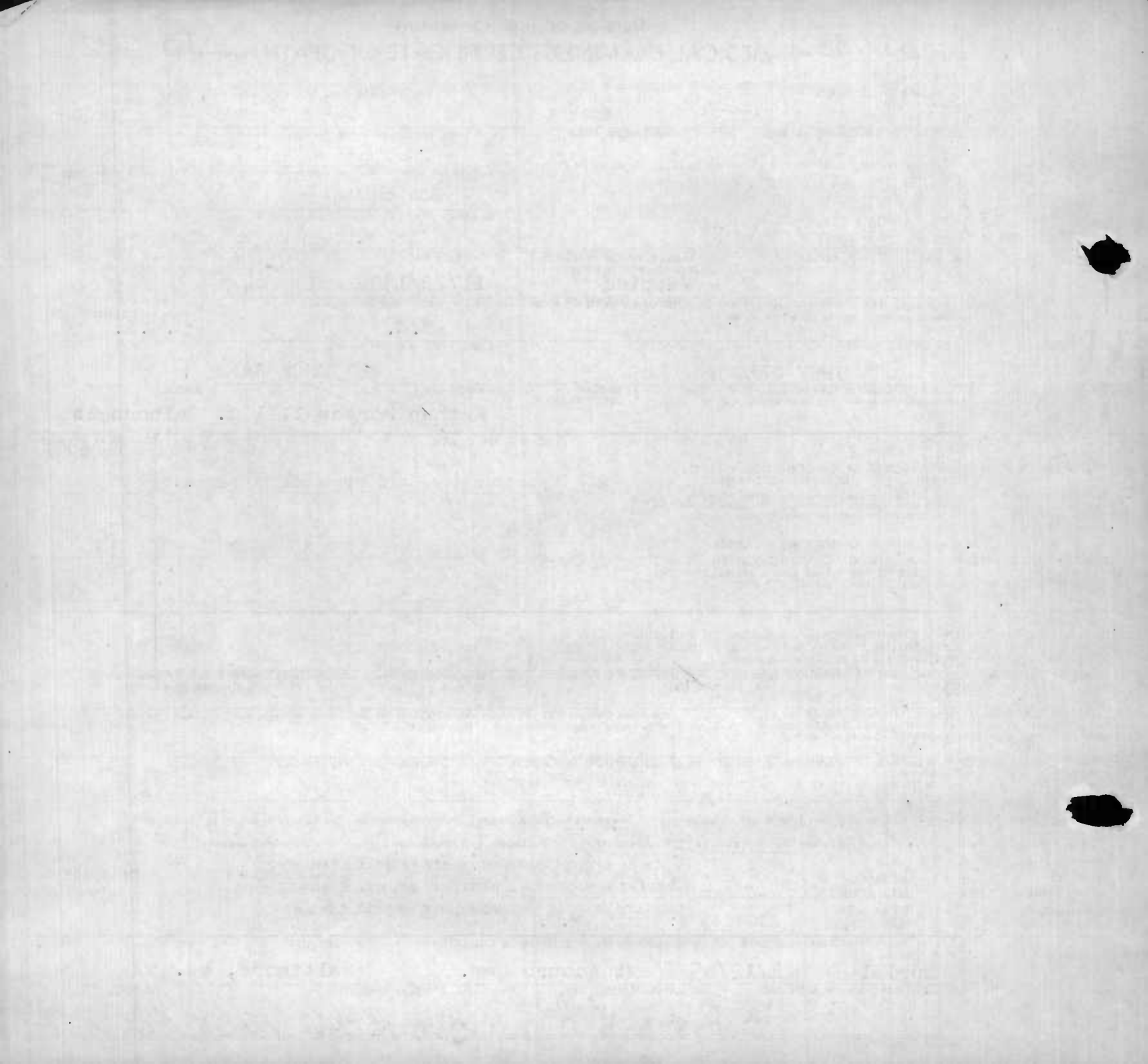
24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

George A. Kline 1348 N. Calhoun St.

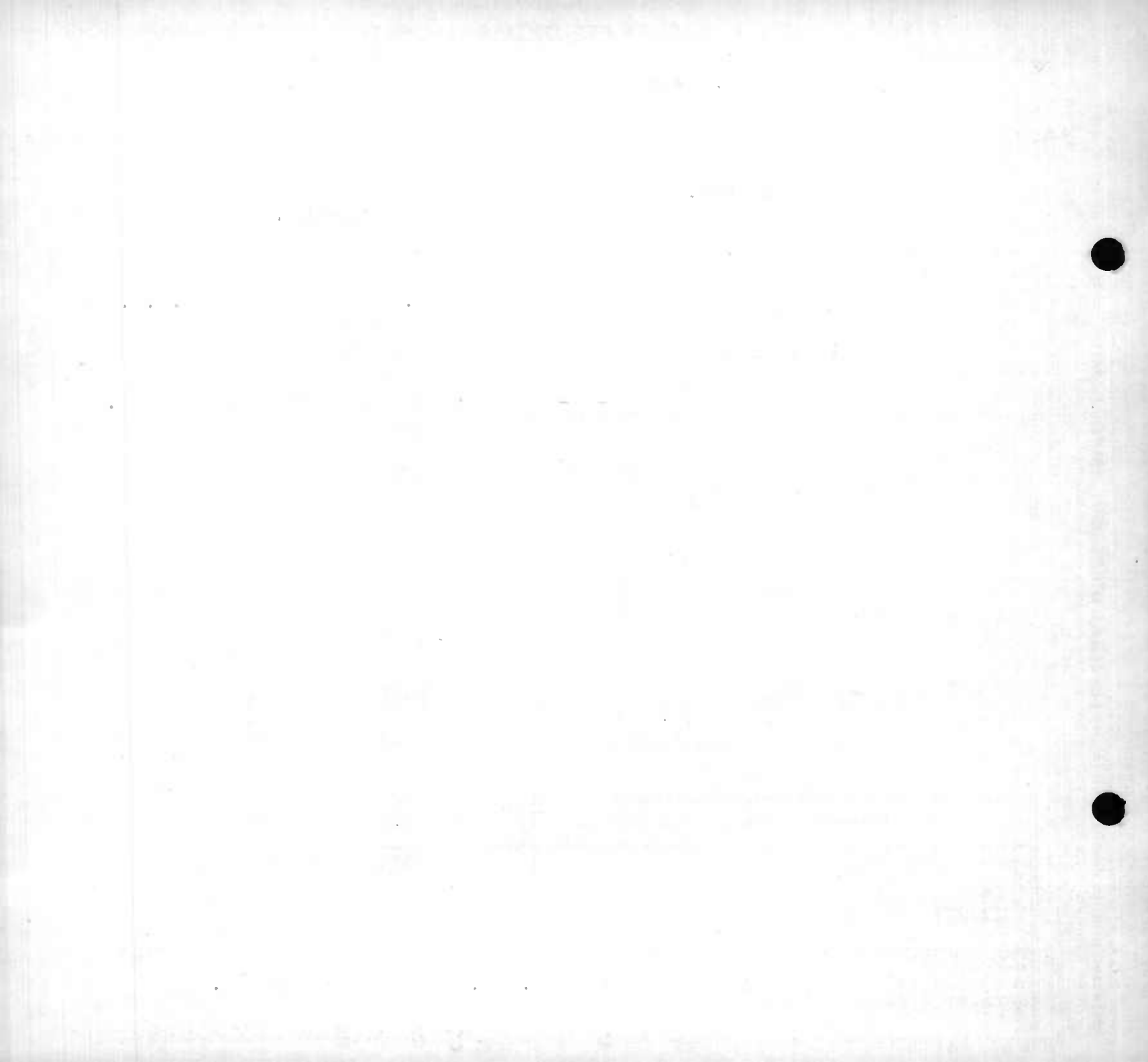
ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |                         |  | BIRTH NO. 65 3822  |  | CERTIFICATE OF DEATH   |  | Registered No. 65 3822                        |  |
|---|--|-------------------------|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM W. Oakley</b>   |  |                         |  | 2. DATE AND HOUR OF DEATH<br><b>April 7, 1965</b> <b>10:39 A.M.</b>  |  |  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Provident Hosp.</b>   |  |                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>16-02</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>914 Stricker St.</b> |  |  |  |   |  |
| 5. SEX<br><b>Male</b>   |  | 6. RACE<br><b>Negro</b> |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>   |  | 8. DATE OF BIRTH<br><b>11/15/06</b>                          |  | 9. AGE (In years last birthday)<br><b>58</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>      |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |
| 13. FATHER'S NAME<br><b>Wallace Oakley</b>  |  |                         |  | 14. MOTHER'S MAIDEN NAME<br><b>Nannie</b>  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |                         |  | 16. SOCIAL SECURITY NO.<br><b>226-18-4756</b>  |  | 17. INFORMANT ADDRESS<br><b>Alice Smith 914 Stricker St.</b> |  |   |  |
| 18. <b>443X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><br>MEDICAL CERTIFICATION<br>19A. DATE OF OPERATION<br><b>0</b><br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>4/5/65</b><br>20A. AUTOPSY? (Yes or No)<br><b>NO</b><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>NO</b><br>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examiner)<br><input type="checkbox"/><br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>HOME</b><br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>HOME</b><br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br><b>APRIL 7 1965</b><br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br><b>HEMIPLEGIA</b><br>22. I certify that (I) (this hospital) attended the deceased from <b>JAN 1 1965</b> to <b>APRIL 7 1965</b> , that (I) (we) last saw the deceased alive on <b>APRIL 7 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.<br>23A. SIGNATURE<br><b>GILBERT L. BANKFIELD</b><br>M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/><br>23B. DATE SIGNED<br><b>4/9/65</b><br>23C. PHYSICIAN'S NAME (Type)<br><b>GILBERT L. BANKFIELD</b><br>M.D.<br>23D. ADDRESS<br><b>722 N. JEFFERSON</b><br>24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b><br>24B. DATE<br><b>4/11/65</b><br>24C. NAME OF CEMETERY or CREMATORY<br><b>Arbutus Mem. Pk.</b><br>24D. LOCATION (City, town, or county) (State)<br><b>Arbutus Md.</b><br>25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 9 1965</b><br>25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b><br>25C. FUNERAL DIRECTOR<br><b>George A. Allen</b><br>ADDRESS<br><b>1518 N. Calhoun St</b> |  |                         |  |  |  |  |  |   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3823  |         |  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3823   |                       |
|--|---------|--|------------------|---|--|--|-----------------------|
| M.E. CASE NO.  |         |  |                  | 1. NAME OF DECEASED   |  | 2. DATE AND HOUR OF DEATH  |                       |
| (Type or Print)  |         |  |                  | George - <del>I. Irvin</del> Ziegler  |  | April 8, 1965 8:30 P. M.   |                       |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                     |  | A. STATE B. COUNTY   |                       |
| HOSPITAL OR INSTITUTION  |         |  |                  | Maryland  |  | 27-34  |                       |
| 5303 Walther Blvd  |         |  |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)   |  | Baltimore  |                       |
| D. STREET ADDRESS (If rural, give location)  |         |  |                  | 5303 Walther Blvd   |  |  |                       |
| 5. SEX   | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)   | If Under 1 Yr. Months: Days: Hours: Min. |  | If Under 24 Hrs. Min. |
| male   | white   | married  | Feb. 10th 1891   | 74  |  |  |                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |                       |
| Livery Business  |         |  |                  | Baltimore, Maryland   |  | U.S.A.   |                       |
| 13. FATHER'S NAME  |         |  |                  | 14. MOTHER'S MAIDEN NAME  |  |  |                       |
| George W. Ziegler  |         |  |                  | ?   |  |  |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT   |  | ADDRESS  |                       |
|  |         | 215-32-9075  |                  | Mrs. Pearl M. Ziegler   |  | 5303 Walther Blvd  |                       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |         |  |                  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH                                     |                       |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |         |  |                  | (A) DUE TO  |  | ?  |                       |
| ANTECEDENT CAUSES  |         |  |                  | (B) DUE TO  |  |  |                       |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         |  |                  | (C)   |  |  |                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |                  | PYELONEPHRITIS, chronic   |  | 1 yr -   |                       |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                       |
| 0  |         |  |                  |   |  |  |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |                       |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?  |  |  |                       |
|  |         | White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>        |                  |   |  |  |                       |
| 22. I certify that (I) (this hospital) attended the deceased from 2-14-1957 to 4-8-1965, that (I) (we) last saw the deceased alive on 3-22-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |   |  |  |                       |
| 23A. SIGNATURE   |         |  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED   |                       |
| DR J. SKLOVEN  |         |  |                  |   |  | 4-9-65   |                       |
| 23C. PHYSICIAN'S NAME (Type)   |         | 23D. ADDRESS   |                  | 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |                       |
| DR J. SKLOVEN  |         | 7122 Harford Road  |                  | Burial  |  | 4/12/65  |                       |
| 24C. NAME OF CEMETERY or CREMATORY   |         | 24D. LOCATION (City, town, or county) (State)  |                  | 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |                       |
| Druid Ridge Cemetery   |         | Baltimore, Maryland  |                  | APR 9 1965  |  | Robert E. Skloven  |                       |
| 25C. FUNERAL DIRECTOR  |         | 25D. ADDRESS   |                  | 25E. NAME OF REGISTRAR  |  | 25F. ADDRESS   |                       |
| Leonard J. Ruck Inc  |         | 5305 Harford Rd.   |                  | Robert E. Skloven   |  |  |                       |

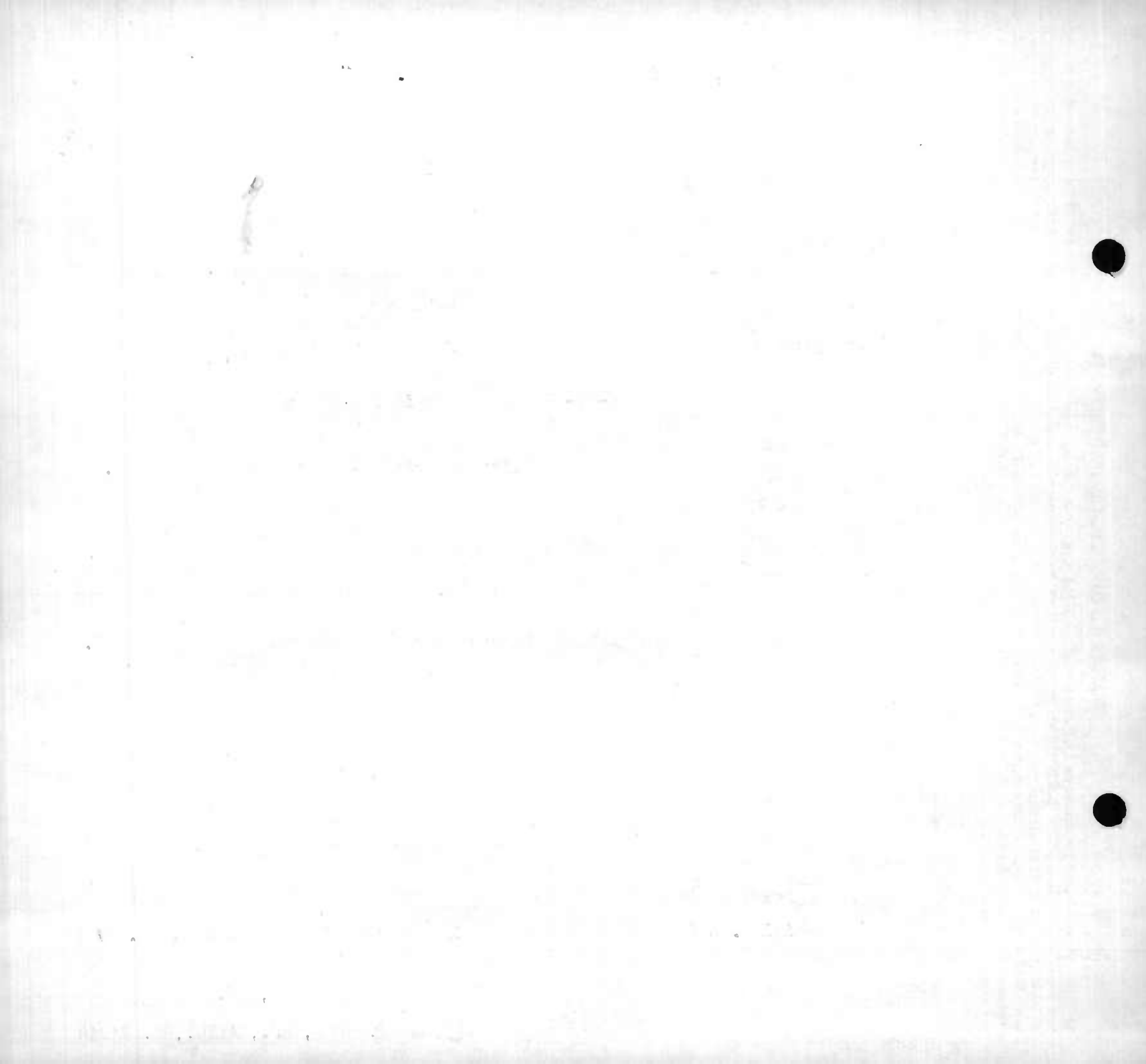
11/10/65  
V. S. 153



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

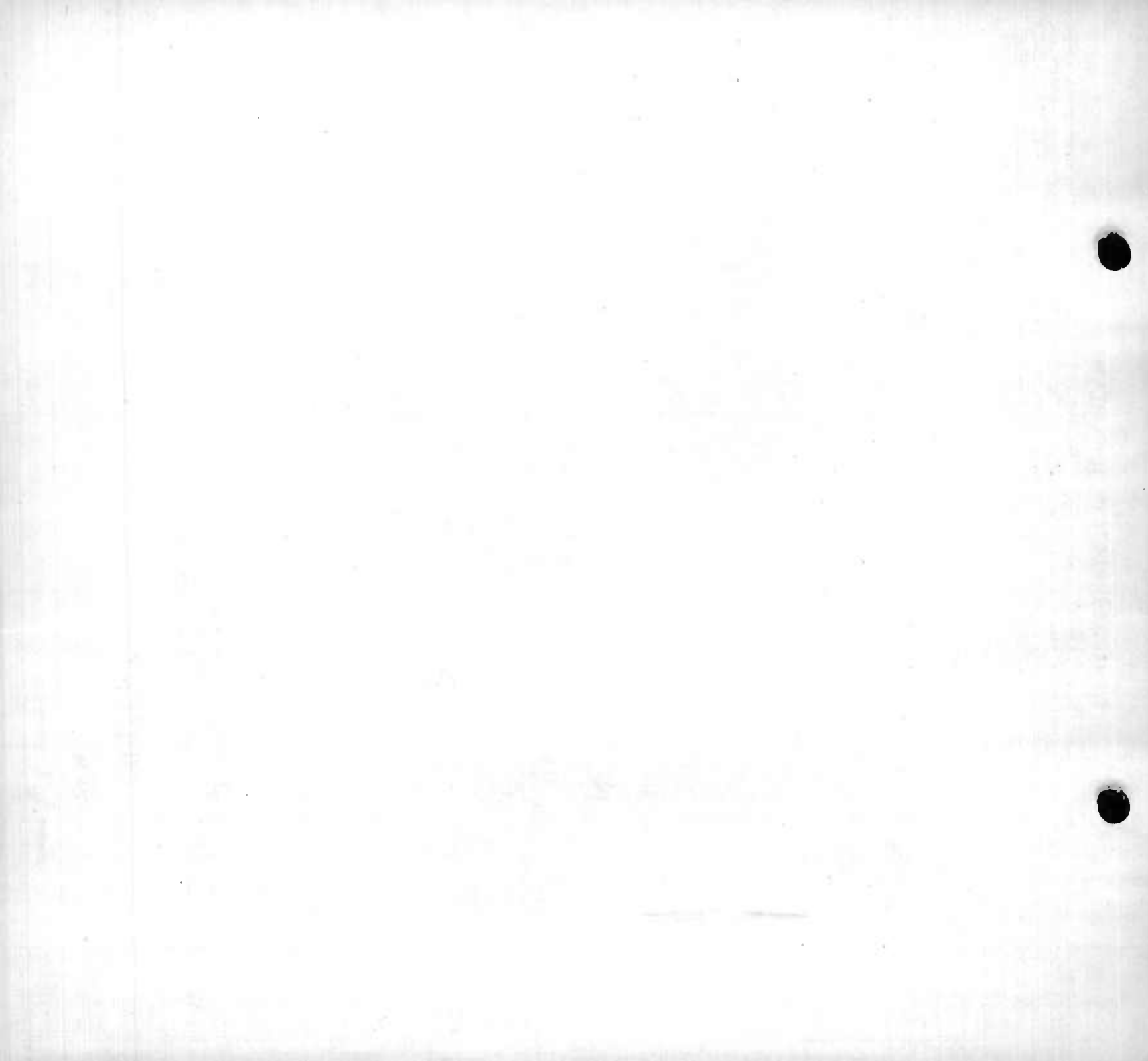
| BIRTH NO. 65 3824  |                  |   |                              | BALTIMORE CITY HEALTH DEPARTMENT  |                            | CERTIFICATE OF DEATH   |                             | Registered No. 65 3824                     |  |
|--|------------------|---|------------------------------|---|----------------------------|--|-----------------------------|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) Pfeiffer, Carrie Lee  |                  |   |                              | 2. DATE AND HOUR OF DEATH<br>4/9/65   |                            | 12:10 A. M.  |                             |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Montebello State Hospital   |                  |   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore<br>D. STREET ADDRESS (If rural, give location) 2509 Windsor Road |                            |  |                             |  |  |
| 5. SEX<br>Female   | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Widow   | 8. DATE OF BIRTH<br>2/3/1898 | 9. AGE (In years last birthday)<br>67   | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |                            | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                  |                             |  |  |
| 13. FATHER'S NAME<br>Elmer Lyons (   |                  |   |                              | 14. MOTHER'S MAIDEN NAME<br>Jennie Cyshner  |                            |  |                             |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                  | 16. SOCIAL SECURITY NO.<br>578-07-8196 D  |                              | 17. INFORMANT<br>Hospital Records   |                            |  |                             | ADDRESS                                    |  |
| 18. 3824 X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |                              | CAUSE OF DEATH<br>(A) Repeated Cerebral thrombosis<br>DUE TO<br>(B) DUE TO<br>(C) DUE TO  |                            |  |                             | INTERVAL BETWEEN ONSET AND DEATH<br>3 yrs. |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |   |                              | Arteriosclerotic heart disease  |                            |  |                             | Some yrs.                                  |  |
| 19A. DATE OF OPERATION<br>O  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No)   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                            |  |                             |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                              | 21F. HOW DID INJURY OCCUR?  |                            |  |                             |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3/15/65 19 to 4/9/65 19, that (I) (we) last saw the deceased alive on 4/9/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                              |   |                            |  |                             |  |  |
| 23A. SIGNATURE<br>Daniel G. Lai  |                  |   |                              | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                            |  |                             | 23B. DATE SIGNED<br>4/9/65                 |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Daniel G. Lai  |                  |   |                              | 23D. ADDRESS<br>M.D. 2201 Argonne Drive, Baltimore, Md. 21218   |                            |  |                             |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>4/12/65  |                              | 24C. NAME of CEMETERY or CREMATORY<br>MORELAND MEMORIAL CEMETERY  |                            | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE, MD.      |                             |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 9 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.  |                              | 25C. FUNERAL DIRECTOR<br>LEONARD J. RUCK, INC., BALTO., MD. 21214   |                            |  |                             | ADDRESS                                    |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

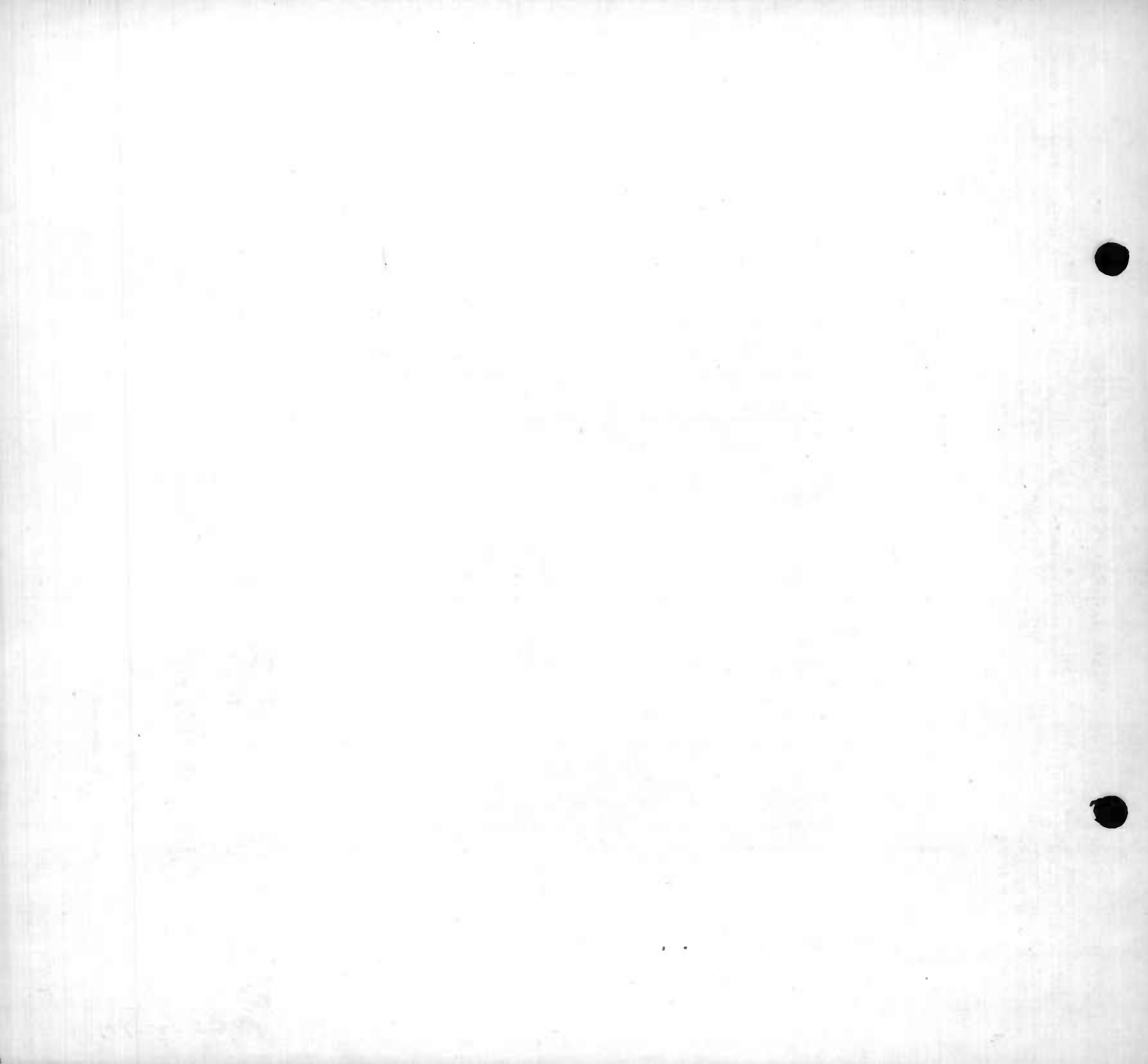
| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  | Certificate of Death   |  | Registered No. 65 3825   |  |
|---|--|---|--|--|--|--|--|
| BIRTH NO.<br>65 3825  |  | M.E. CASE NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) <i>Cheatham, J. Russell</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>4/9/65 17<sup>10</sup> A.M.</i>          |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><i>Lutheran Hosp. of Md.</i><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY <i>BALTIMORE CITY</i> |  |  |  |
| 5. SEX <i>male</i>  |  |   |  | 6. RACE <i>color</i>   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><i>Widowed</i> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired</i>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Truck driver</i>  |  | 8. DATE OF BIRTH<br><i>3-8-1891</i>  |  | 9. AGE (In years last birthday) <i>74</i>                                |  |
| 11. BIRTHPLACE (State or foreign country)<br><i>Henderson, N.C.</i>   |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |  |  |  |
| 13. FATHER'S NAME<br><i>Et Cheatham</i>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Malenda Landon</i>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |  | 16. SOCIAL SECURITY NO.<br><i>244-01-1195</i>   |  | 17. INFORMANT<br><i>Jana Harper</i>  |  | ADDRESS<br><i>1111 Ashburton St.</i>                                     |  |
| 18. <i>331X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                       |  |   |  | (A) <i>cardiovascular accident</i><br>DUE TO   |  | (B) <i>CVA and pneumonia</i><br>DUE TO                                   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  | (C) _____  |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><i>No</i>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?     |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/3</i> 19 <i>65</i> to <i>4/9</i> 19 <i>65</i> , that (I) <i>we</i> last saw the deceased alive on <i>7<sup>10</sup> AM 4/9</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br><i>Rajasee</i>  |  |   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>         |  | 23B. DATE SIGNED<br><i>4/9/65</i>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Dr. Saroosh Rajasee</i>  |  |   |  | 23D. ADDRESS<br>M.D.   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |  | 24B. DATE<br><i>4-13-65</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Whitman Mem. Pk.</i>  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md.</i>    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 12 1965</i>   |  | 25B. NAME OF REGISTRAR<br><i>Robert E. Fisher</i>   |  | 25C. FUNERAL DIRECTOR<br><i>William A. Phillips</i>  |  | ADDRESS<br><i>1727 N. Monmouth</i>                                       |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                      |   |                                    |  |  |
|---|----------------------|---|------------------------------------|--|--|
| BIRTH NO. 65 3826   |                      | BALTIMORE CITY HEALTH DEPARTMENT  |                                    | Registered No. 65 3826   |  |
| M.E. CASE NO.   |                      | 1. NAME OF DECEASED<br>(Type or Print) <i>Cornell Baylor</i>  |                                    | 2. DATE AND HOUR OF DEATH<br><i>4/16/65 10:30 P.M.</i>                   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>University Hospital</i>   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>16-04</i><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i><br>D. STREET ADDRESS (If rural, give location)<br><i>1808 Riggs Ave</i> |                                    |  |  |
| 5. SEX <i>♂</i>   | 6. RACE <i>Negro</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>separated</i>  | 8. DATE OF BIRTH<br><i>4/17/49</i> | 9. AGE (in years lost birthday) <i>45</i>                                | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Librarian</i>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>Baltimore, Md.</i>       |  |
| 13. FATHER'S NAME<br><i>John H. Baylor</i>  |                      | 14. MOTHER'S MAIDEN NAME<br><i>Anna Callaway</i>  |                                    | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes/no or unknown) (If yes, give war or dates of service)<br><i>yes WW II</i>   |                      | 16. SOCIAL SECURITY NO.<br><i>213-03-5813</i>   |                                    | 17. INFORMANT ADDRESS<br><i>Salaman Baylor 709 McKean Ave</i>            |  |
| 18. <i>490X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      | (A) <i>Cardiac arrest</i><br>DUE TO<br>(B) <i>RLL pneumonia</i><br>DUE TO<br>(C)  |                                    | INTERVAL BETWEEN ONSET AND DEATH   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                      |   |                                    |  |  |
| 19A. DATE OF OPERATION<br><i>3/16/65</i>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><i>Tracheostomy for breathing</i>   |                                    | 20A. AUTOPSY? (Yes or No) <i>Yes</i>                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)  |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/16</i> 19 <i>65</i> to <i>4/16</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4/16</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |   |                                    |  |  |
| 23A. SIGNATURE<br><i>Jonathan Tuerk</i>   |                      | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                                    | 23B. DATE SIGNED<br><i>4/16/65</i>                                       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Jonathan Tuerk M.D.</i>  |                      | 23D. ADDRESS<br><i>University Hospital</i>  |                                    |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                      | 24B. DATE<br><i>4-12-65</i>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><i>Baltimore National</i>          |  |
| 24D. LOCATION<br><i>Baltimore Md.</i>   |                      | 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 12 1965</i>   |                                    |  |  |
| 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |                      | 25C. FUNERAL DIRECTOR<br><i>Belington Phillips</i>  |                                    | ADDRESS<br><i>1727 N. Mount St.</i>                                      |  |



BIRTH NO.

65 3827

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 3827

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CARRIE

FORD

2. DATE AND HOUR PRONOUNCED DEAD

April 8, 1965

8:22 A M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Franklin Square Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

918 Gilmor Street

5. SEX

Female

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced

8. DATE OF BIRTH

Oct. 26, 1929

9. AGE (in years  
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

House wife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

South Carolina

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Ben Ford

14. MOTHER'S MAIDEN NAME

Olethia Woodard

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No.

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Thomas Squirewell 1524 Edison Hwy

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Rheumatic Heart Disease.  
DUE TO

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

CHIEF MEDICAL EXAMINER ☐

M.D.

ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/8/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-12-65

23C. NAME of CEMETERY or CREMATORY

Ashburton Memorial Ph. Bacterium

23D. LOCATION

(City, town, or county)

(State)

Md.

24A. DATE REC'D BY HEALTH DEPT.

APR 12 1965

24B. NAME OF REGISTRAR

Robert E. Farkner

24C. FUNERAL DIRECTOR

Arlington Phillips 1727 N. Monmouth St.

ADDRESS

WALL GLEY PHOTOGRAPH



1

65 3828

BALTIMORE CITY HEALTH DEPARTMENT

65 3828

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_

M.E. CASE NO. \_\_\_\_\_

1. NAME OF DECEASED (Type or Print) **DARNELL WHITE**

2. DATE AND HOUR PRONOUNCED DEAD **4/9/65 4:00 p. M.**

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE **Maryland** B. COUNTY \_\_\_\_\_

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) **Baltimore**

D. STREET ADDRESS (If rural, give location) **426 E. 22nd St.**

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) **Union Memorial Hospital**

5. SEX **male** 6. RACE **colored** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) \_\_\_\_\_

8. DATE OF BIRTH **April 27, 1960** 9. AGE (In years last birthday) **4** If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10B. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) **Balto., Md.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **Nelson White** 14. MOTHER'S MAIDEN NAME **Mary Skinner**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **Mary White** ADDRESS **426 E. 22nd Street**

18. **E 812.7** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH **Multiple traumatic injuries**

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(A) DUE TO \_\_\_\_\_

(B) DUE TO \_\_\_\_\_

(C) \_\_\_\_\_

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) **no** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **street** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) **Greenmount and 22½ St. 12-04**

21D. TIME OF INJURY (APPROX.) **4 9 65 2:37 p. m.** 21E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 21F. HOW DID INJURY OCCUR? **struck by bus**

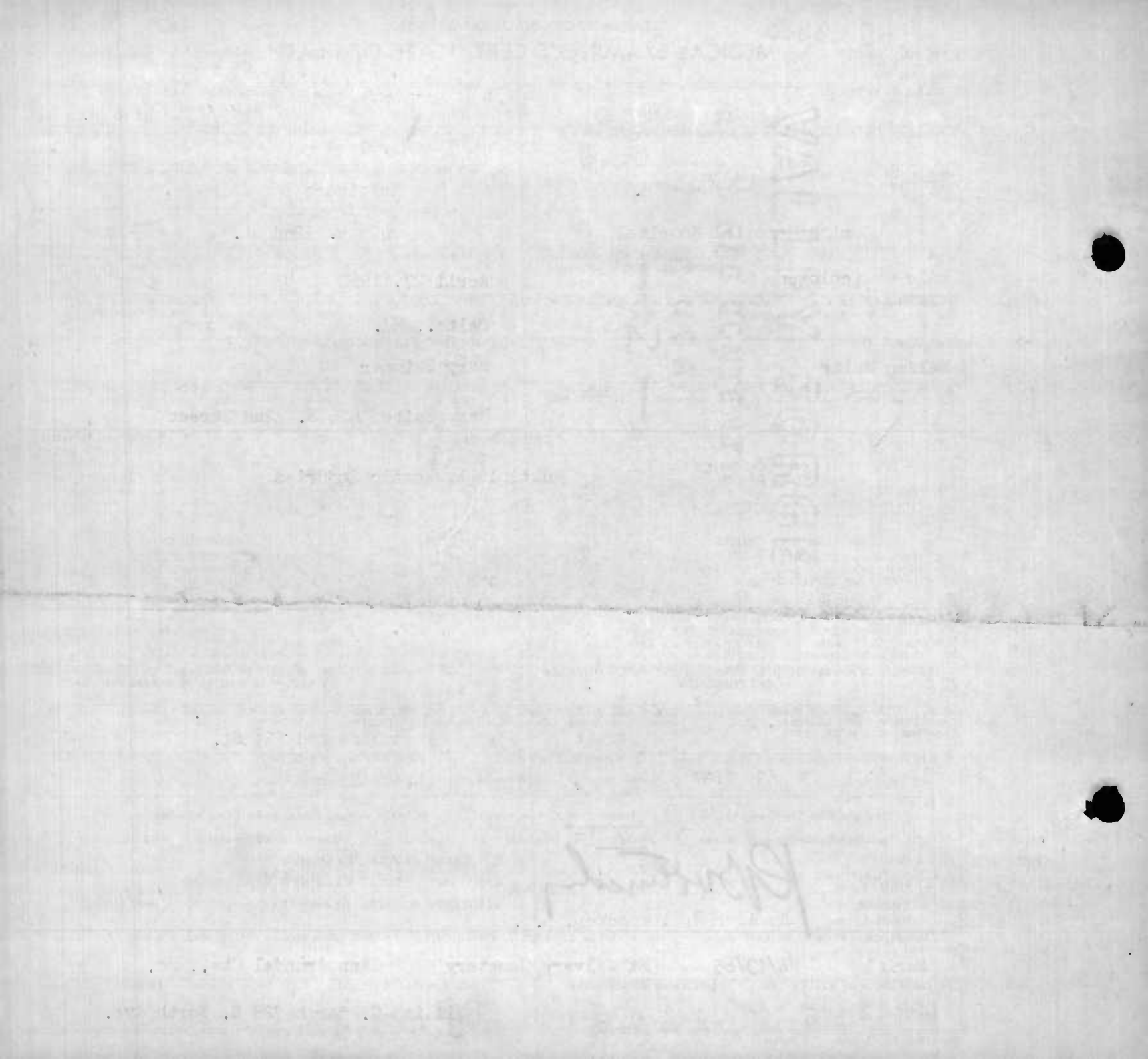
22. I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Rudiger Breitenecker, M.D.** CHIEF MEDICAL EXAMINER ☐ DATE SIGNED **4/10/65**

EXAMINER'S NAME (Type) **Rudiger Breitenecker, M.D.** ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐

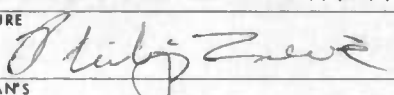
23A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 23B. DATE **4/13/65** 23C. NAME of CEMETERY or CREMATORY **Mt Calvary Cemetery** 23D. LOCATION (City, town, or county) (State) **Ann Arundel Cty., Md.**

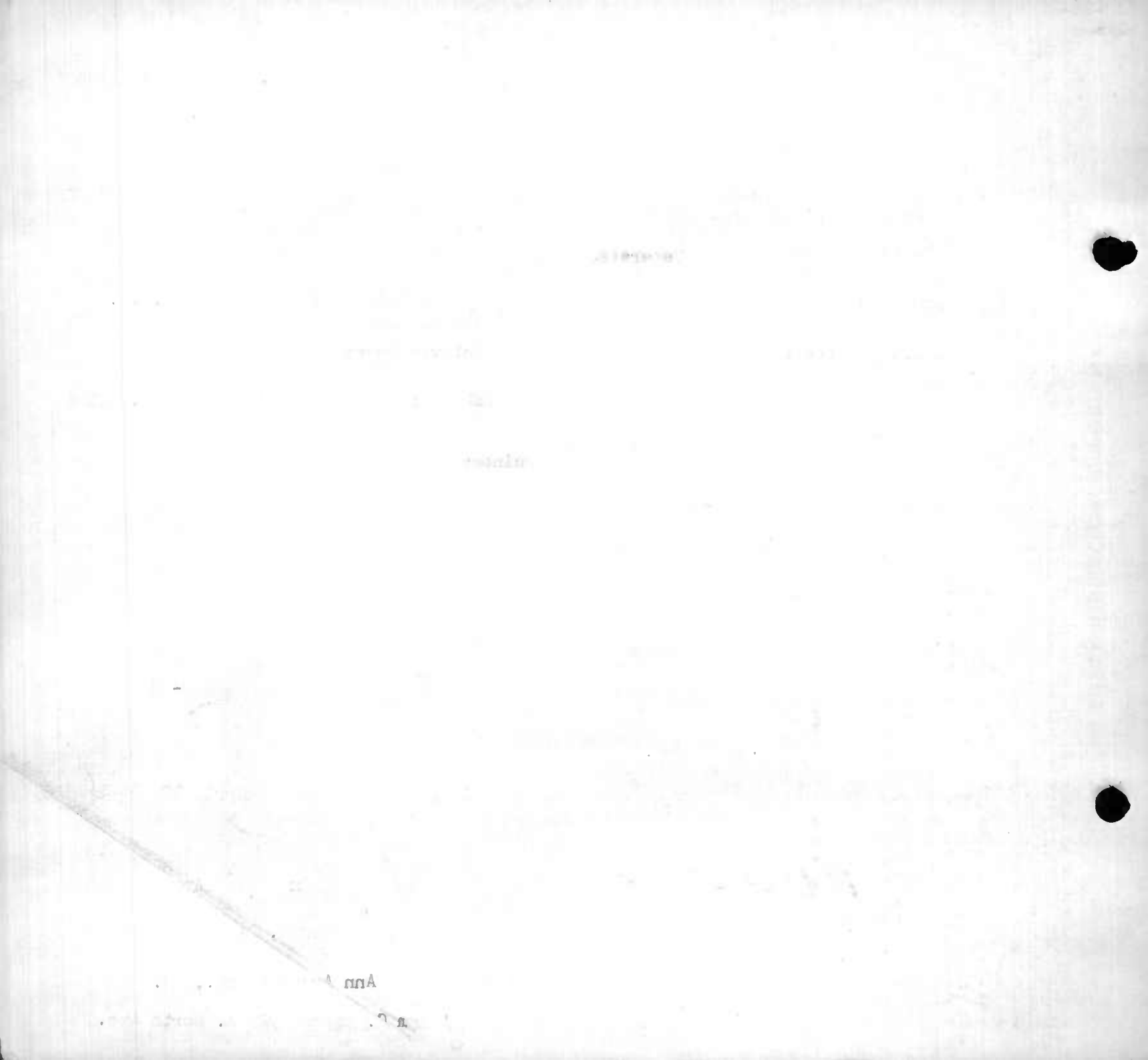
24A. DATE REC'D BY HEALTH DEPT. **APR 12 1965** 24B. NAME OF REGISTRAR **William C. March** 24C. FUNERAL DIRECTOR **March 928 E. North Ave.** ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

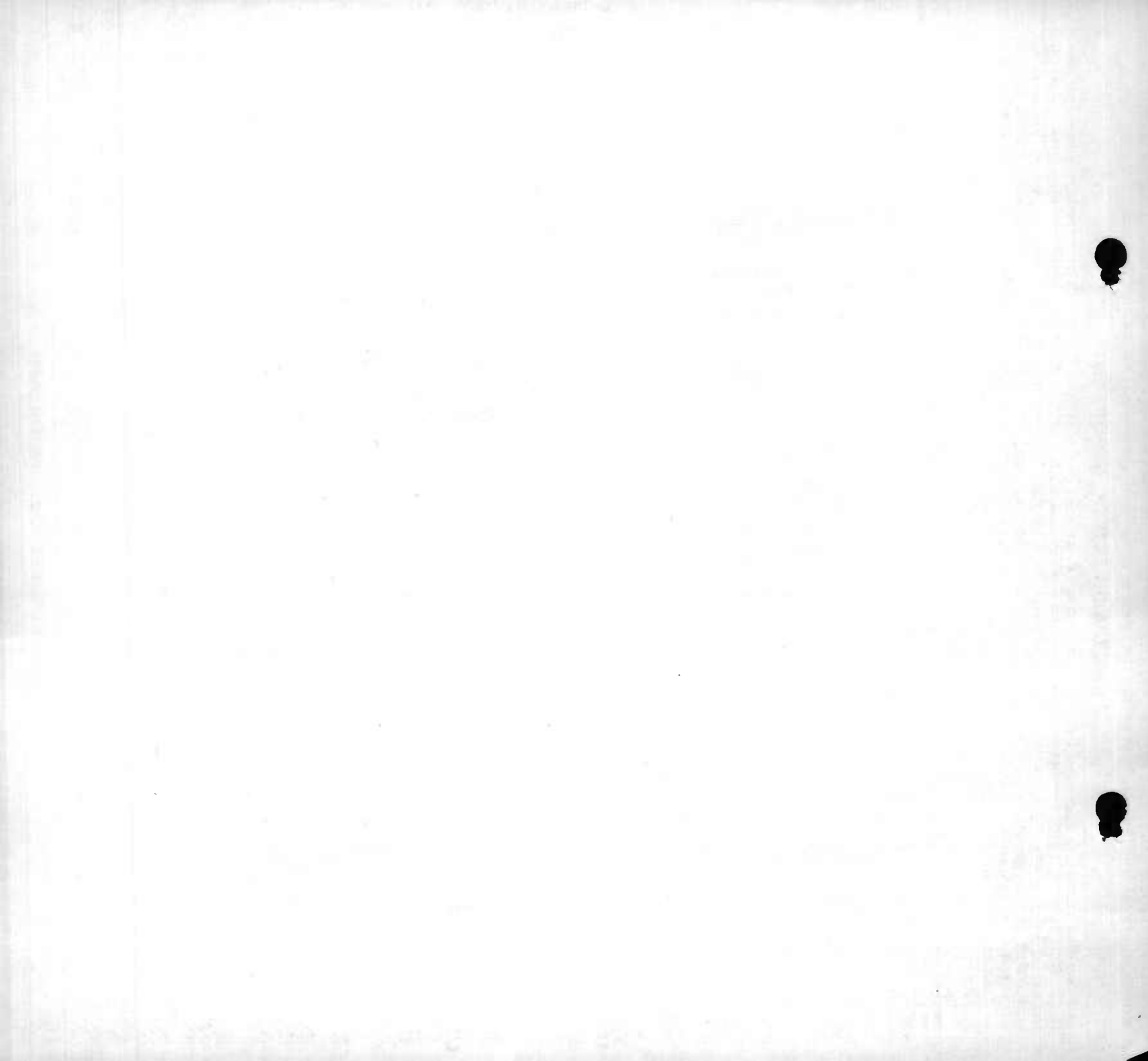
|  |  |   |  |   |  |  |  |   |  |
|--|--|---|--|---|--|--|--|---|--|
| 43-26-81<br>CRF<br>1423  |  | BALTIMORE DEPARTMENT  |  | BIRTH NO. 65 3829   |  | CERTIFICATE OF DEATH   |  | Registered No. 65 3829                            |  |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print) <b>Martha Alston</b>   |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>April 10, 1965 12 Noon</b>  |  |  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals<br/>4940 Eastern Avenue<br/>Baltimore, Maryland, 21224</b>  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>14-03</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1826 Druidhill Avenue, 21217</b> |  |  |  |   |  |
| 5. SEX<br><b>Female</b>  |  | 6. RACE<br><b>Negro</b>   |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Separated</b>  |  | 8. DATE OF BIRTH<br><b>2-10-1918</b>   |  | 9. AGE (In years lost birthday)<br><b>47</b>      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>                       |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>     |  |
| 13. FATHER'S NAME<br><b>Charles Burrell</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Octavia Moore</b>  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>RECORDS: BCH, 4940 Eastern Avenue, 21224</b>           |  |   |  |
| 18. I <b>170X</b> I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |  |   |  | CAUSE OF DEATH<br>(A) <b>Carcinoma of the Breast</b><br>DUE TO<br><br>(B) _____<br>DUE TO<br><br>(C) _____  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b> |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b> |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 5, 1965</b> to <b>April 10, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 10, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.              |  |   |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br>  |  |   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><b>April 10, 1965</b>  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>PHILLIP ZIEVE</b>   |  |   |  | 23D. ADDRESS<br>M.D. <b>4940 Eastern Avenue, 21224</b>  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>4/15/65</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt Calvary Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Ann Arundel Cty., Md.</b>      |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fajana</b>   |  | 25C. FUNERAL DIRECTOR<br><b>William C. March</b>  |  | ADDRESS<br><b>928 E. North Ave.</b>  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department   |         |  |   | Registered No.   |  |
|--|---------|--|---|--|--|
| BIRTH NO.  |         | 65 3830  |   | 65 3830  |  |
| M.E. CASE NO.  |         |  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |         |  | 2. DATE AND HOUR OF DEATH   |  |  |
| MARTHA HACKLEY   |         |  | 140 PM 4/8/65   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |         |  | A. STATE B. COUNTY  |  |  |
| UNIVERSITY HOSP.   |         |  | MD BALTO  |  |  |
|  |         |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |  |
|  |         |  | BALTO   |  |  |
|  |         |  | D. STREET ADDRESS (If rural, give location)   |  |  |
|  |         |  | 1603 SPRAY CT   |  |  |
| 5. SEX   | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                   | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| F  | C       | Married  | 11-1-24   | 40   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |  |
|  |         |  |   | Maryland   |  |
| 13. FATHER'S NAME  |         |  | 14. MOTHER'S MAIDEN NAME  |  |  |
| William F. Ennis   |         |  | Ada M. Bond   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT ADDRESS  |  |
| NO   |         | 217-14-9481  |   | Brucely Hackley 1603 Spray Ct.   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)  |         |  | CAUSE OF DEATH  |  |  |
|  |         |  | Anomalous Cell Corrosion 14mo. Bonepallory Series                                     |  |  |
| ANTECEDENT CAUSES  |         |  | (B) DUE TO  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         |  | (C)   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |   |  |  |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  |
| February 1964  |         | nasal polypectomy  |   | NO   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| none   |         | none   |   | none   |  |
| 21D. TIME OF INJURY (APPROX.)  |         | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?   |  |
|  |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4-7-1965 to 4-8-1965, that (I) (we) last saw the deceased alive on 4-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |   |  |  |
| 23A. SIGNATURE   |         |  |   | 23B. DATE SIGNED   |  |
| Louis M. Damiano   |         |  |   | 4/8/65   |  |
| 23C. PHYSICIAN'S NAME (Type)   |         | 23D. ADDRESS   |   |  |  |
| LOUIS M. DAMIANO   |         | Univ. Hosp.  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE  |   | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| Burial   |         | 4-12-65  |   | Greenview Mem. PK.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR ADDRESS  |  |
| APR 12 1965  |         | Robert E. Finkbeiner   |   | George A. Kilar 1348 N. Calton St  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |               |  |                            |  |  |  |  |
|---|---------------|--|----------------------------|--|--|--|--|
| 31-79-65<br>CRF<br>P-2000   |               | BIRTH NO. 65 3831  |                            | BALTIMORE CITY HEALTH DEPT.  |  | Registered No. 65 3831   |  |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) George Peace  |               |  |                            | 2. DATE AND HOUR OF DEATH April 10, 1965 5 A.M.  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><b>CERTIFICATE CORRECTED 4-19-65</b><br>HOSPITAL OR INSTITUTION Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland, 21224   |               |  |                            | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore<br>D. STREET ADDRESS (If rural, give location) 2904 Auchentoroly Terrace 21217 |  |  |  |
| 5. SEX Male   | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married   | 8. DATE OF BIRTH 4-12-1900 | 9. AGE (In years last birthday) 64   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labour  |               | 10B. KIND OF BUSINESS OR INDUSTRY Sparrows Point   |                            | 11. BIRTHPLACE (State or foreign country) Virginia   |  | 12. CITIZEN OF WHAT COUNTRY? USA                                     |  |
| 13. FATHER'S NAME George Peace  |               |  |                            | 14. MOTHER'S MAIDEN NAME Annie Dickerson   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |               | 16. SOCIAL SECURITY NO. 335-07-1598  |                            | 17. INFORMANT ADDRESS RECORDS: BCH, 4940 Eastern Ave., 21224   |  |  |  |
| 18. 934X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |               |  |                            | CAUSE OF DEATH (A) Respiratory Arrest DUE TO Pneumonia (B) Arterio Sclerotic Cerebral DUE TO Vascular Disease (C)  |  | INTERVAL BETWEEN ONSET AND DEATH Min Days Years                      |  |
| 19A. DATE OF OPERATION 0  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            | 20A. AUTOPSY? (Yes or No) No   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                            | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 2nd 19 65 to April 10th 19 65, that (I) (we) last saw the deceased alive on April 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |               |  |                            |  |  |  |  |
| 23A. SIGNATURE Philip Zieve   |               |  |                            | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED April 10, 1965                                      |  |
| 23C. PHYSICIAN'S NAME (Type) PHILIP ZIEVE   |               |  |                            | 23D. ADDRESS M.D. 4940 Eastern Avenue, 21224   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |               | 24B. DATE 4-14-65  |                            | 24C. NAME of CEMETERY or CREMATORY Carver Mem. Pk.   |  | 24D. LOCATION (City, town, or county) Laurel Md.                     |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 12 1965   |               | 25B. NAME OF REGISTRAR Robert E. Jenkins   |                            | 25C. FUNERAL DIRECTOR George H. Kilar  |  | 25D. ADDRESS 1318 N. Galloway St                                     |  |

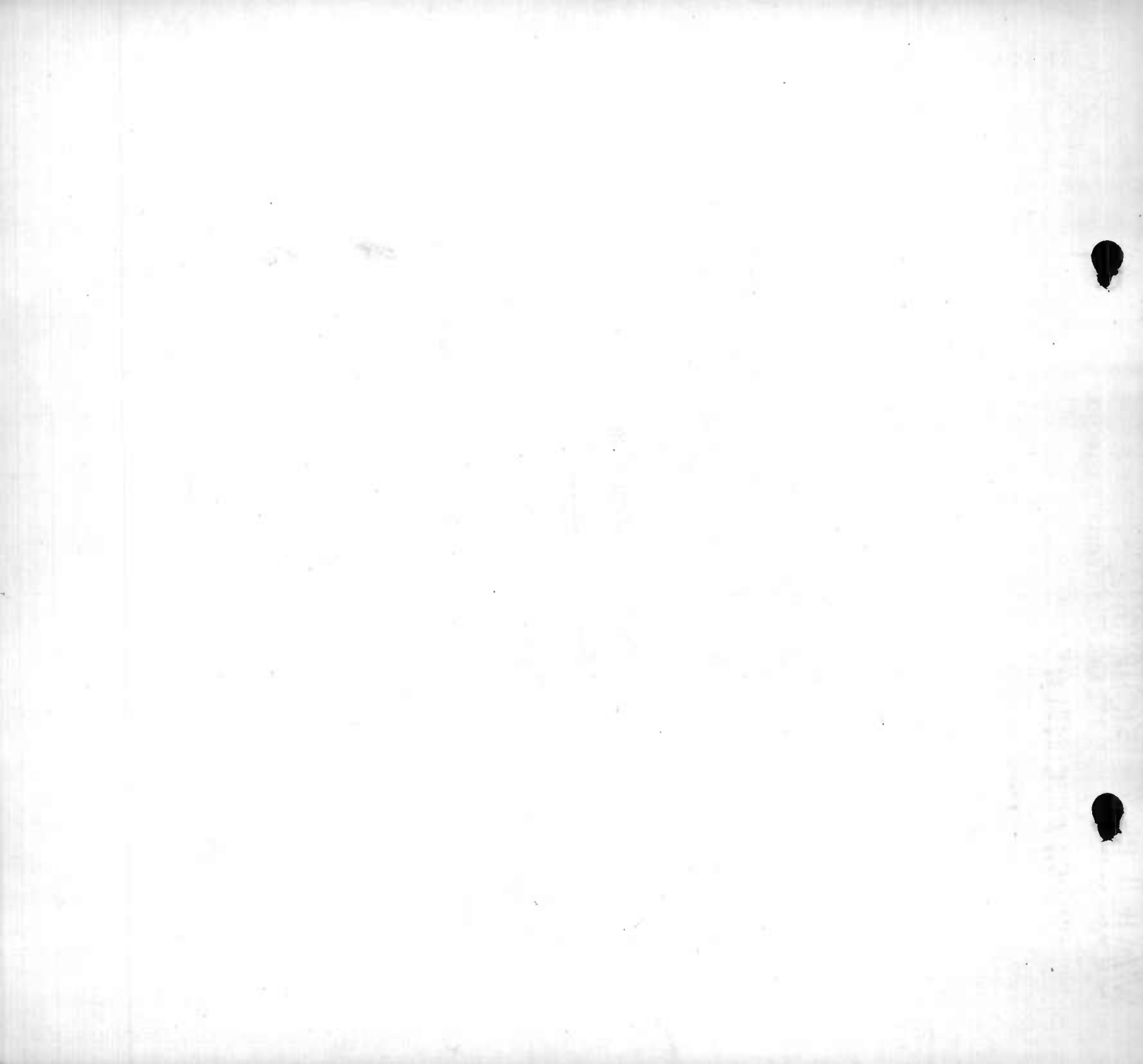
Letter from B.C.H.  
4-19-65 M.H.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

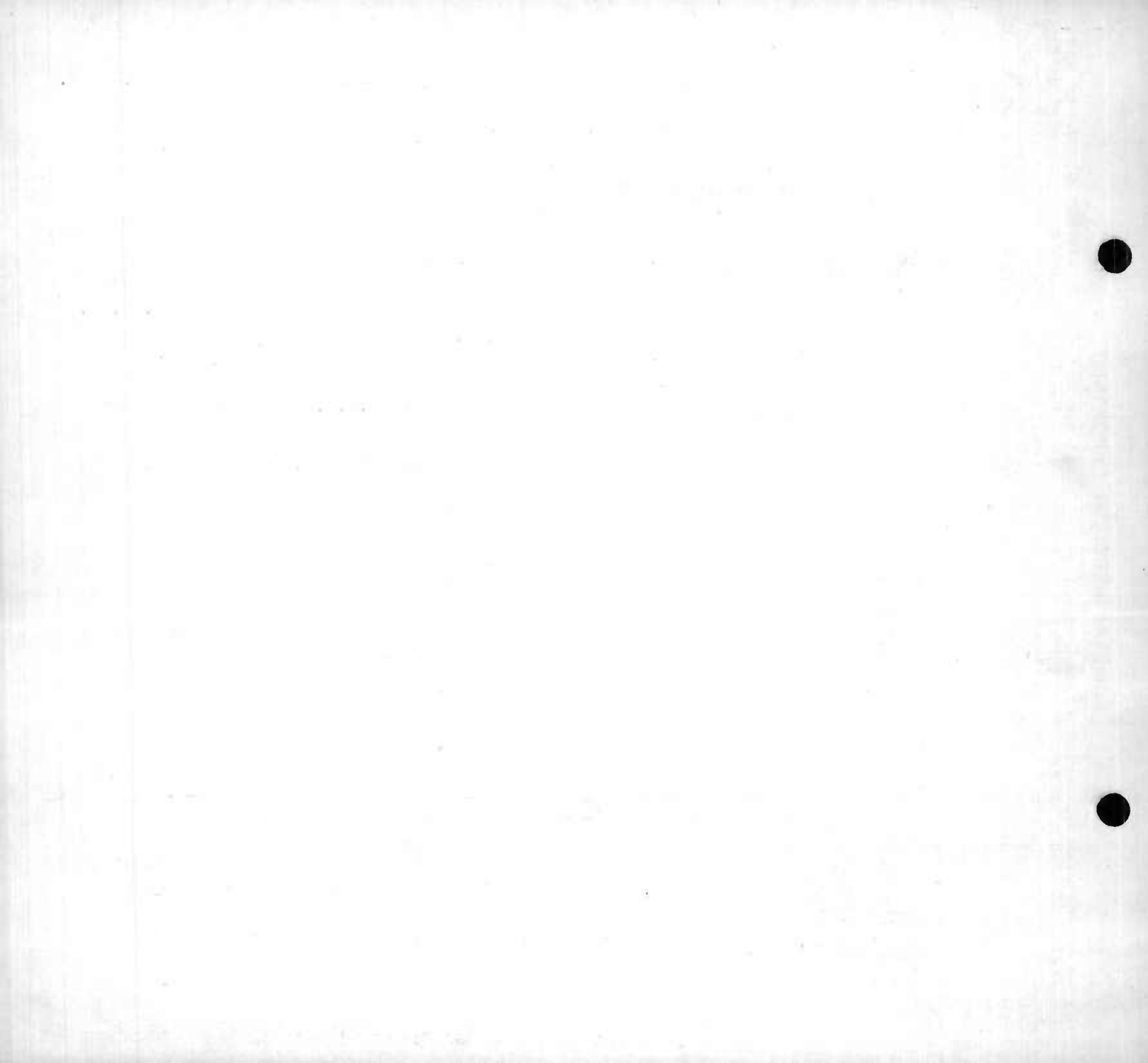
|   |              |  |                             |  |   |
|---|--------------|--|-----------------------------|--|---|
| BIRTH NO. 65 3832   |              | BALTIMORE CITY HEALTH DEPARTMENT   |                             | Registered No. 65 3832   |   |
| M.E. CASE NO.   |              | CERTIFICATE OF DEATH   |                             |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) WILLIAMS, JAMES HARVEY   |              | 2. DATE AND HOUR OF DEATH<br>4/9/65 8:10 P.M.  |                             |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                             |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>FRANKLIN SQUARE HOSPITAL<br>FAYETTE & CALHOUN STS<br>BALTIMORE 23, MD.   |              | A. STATE MARYLAND<br>B. COUNTY 16-02<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE 17<br>D. STREET ADDRESS (If rural, give location)<br>1524 W. LANVALE ST |                             |  |   |
| 5. SEX<br>M   | 6. RACE<br>N | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>MARRIED  | 8. DATE OF BIRTH<br>9/30/08 | 9. AGE (In years last birthday)<br>56  | 10. If Under 1 Yr. Months: Days: 11. If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>LABORER  |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>CARTER CONSTRUCTION   |                             | 11. BIRTHPLACE (State or foreign country)<br>VIRGINIA                            |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |              | 13. FATHER'S NAME<br>HARVEY WILLIAMS   |                             | 14. MOTHER'S MAIDEN NAME<br>BETSY - - ? - -                                      |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>?   |              | 16. SOCIAL SECURITY NO.<br>?   |                             | 17. INFORMANT<br>FLOSSIE MITCHELL (WIFE)<br>ADDRESS<br>1524 LANVALE BALTIMORE 17 |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>3-78X I<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |              | M. CAUSE OF DEATH<br>MARKED PERITONITIS<br>RUPTURED VISCUS (ILEUM)<br>CARDIAC ARREST   |                             | INTERVAL BETWEEN ONSET AND DEATH<br>6 DAYS                                       |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |              |  |                             |  |   |
| 19A. DATE OF OPERATION<br>4/9/65  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>ACUTE ABDOMEN  |                             | 20A. AUTOPSY? (Yes or No)<br>No  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |              |  |                             |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>-  |                             | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br>- |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)<br>-   |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                             | 21F. HOW DID INJURY OCCUR?<br>-  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 4/9 1965 to 4/9 1965, that (I) (we) last saw the deceased alive on 4/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |              |  |                             |  |   |
| 23A. SIGNATURE<br>Artemio M. Cuevas, Jr.<br>M.D.  |              |  |                             | 23B. DATE SIGNED<br>4/9/65   |   |
| 23C. PHYSICIAN'S NAME (Type)<br>ARTEMIO M. CUEVAS, JR.  |              | 23D. ADDRESS<br>FRANKLIN SQUARE HOSPITAL   |                             |  |   |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |              | 24B. DATE<br>4-14-65   |                             | 24C. NAME of CEMETERY or CREMATORY<br>Mt Auburn Cem                              |   |
| 24D. LOCATION (City, town, or county)<br>Baltimore Md.  |              | 24E. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965   |                             |  |   |
| 24F. NAME OF REGISTRAR<br>Robert E. Farber  |              | 24G. FUNERAL DIRECTOR<br>George A. Klen  |                             |  |   |
| 24H. ADDRESS<br>1348 N. Calhoun St  |              |  |                             |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                      |   |  |  |  |
|---|----------------------|---|--|--|--|
| BIRTH NO. 65 3833   |                      | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |  | Registered No. 65 3833   |  |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print)<br><div style="text-align: center;">Sarah Watts</div>   |                      |   | 2. DATE AND HOUR OF DEATH<br>4-7-65 5:20 P. M.   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland #21224  |                      |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>4940 Eastern Avenue #21224 |  |  |
| 5. SEX<br>Female  | 6. RACE<br>Negro     | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Divorced                                      | 8. DATE OF BIRTH<br>6-27-99  | 9. AGE (In years last birthday)<br>65                                    | If Under 1 Yr. Months: Days: Hours: Min.                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                      | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br>Maryland  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                 |
| 13. FATHER'S NAME<br>Robert Garner  |                      |   | 14. MOTHER'S MAIDEN NAME<br>Rebecca Clark  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |                      | 16. SOCIAL SECURITY NO.<br>212-18-5759  | 17. INFORMANT ADDRESS<br>RECORDS: B.C.H. 4940 Eastern Avenue #21224  |  |  |
| 18. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                      |   |  |  | INTERVAL BETWEEN ONSET AND DEATH<br>10 Years<br>10 Years |
| 19A. DATE OF OPERATION<br>0   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br>No  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3-29-19 63 to 4-7-19 65, that (I) (we) last saw the deceased alive on 4-7-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                      |   |  |  |  |
| 23A. SIGNATURE<br>Dr. Charles Carpenter   |                      |   | 23B. DATE SIGNED<br>4-7-65   |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Dr. Charles Carpenter   |                      |   | 23D. ADDRESS<br>4940 Eastern Avenue #21224   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  | 24B. DATE<br>4-13-65 | 24C. NAME of CEMETERY or CREMATORY<br>Mt Calvary Cem.   |  | 24D. LOCATION (City, town, or county) (State)<br>Anne Arundel Co. Md.    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |                      | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |  | 25C. FUNERAL DIRECTOR ADDRESS<br>Stacy A. Kibon 1318 N. Calhoun St       |  |



BIRTH NO.

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** Registered No. \_\_\_\_\_

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOSEPH SILVELS (CEPHERS)

2. DATE AND HOUR PRONOUNCED DEAD

4/8/65

1:45 p.

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

South Baltimore General

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2305 Harford Rd.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Sept 28, 1904

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LONG SHOREMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

U. S. A

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

24-01-7137

17. INFORMANT

ADDRESS

Mother Silvers 2305 Harford Rd.

18.

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Atherosclerotic cardiovascular disease

(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTAINING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

21F. HOW DID INJURY OCCUR?

WHILE AT WORK ☐

NOT WHILE AT WORK ☐

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/9/65

23A. BURIAL CREMATION, REMOVAL (Specify)

Burial

23B. DATE

4-13-65

23C. NAME of CEMETERY or CREMATORY

Arbutus Mem. Pk.

23D. LOCATION

(City, town, or county)

(State)

Arbutus, Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 12 1965

Robert E. Fink

George A. Kellan 1348 N. Calhoun St

VS. 153 signed by funeral Director.

4-15-65

43-29-13

FR

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |                               |  |  |
|---|------------------|---|-------------------------------|--|--|
| BIRTH NO.<br>65 3835  |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |                               | Registered No. 65 3835   |  |
| M.E. CASE NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) Charles J. Vogl  |                               | 2. DATE AND HOUR OF DEATH<br>April 8, 1965 1:30 P. M.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) 5300<br>D. STREET ADDRESS (If rural, give location) 922 Woodlynn Road 21221 |                               |  |  |
| 5. SEX<br>Male  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married   | 8. DATE OF BIRTH<br>3-20-1899 | 9. AGE (In years last birthday)<br>66  | If Under 1 Yr. Months Days Hours Min.<br>If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Eng-Canton Co.   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                               | 11. BIRTHPLACE (State or foreign country)<br>Germany   | 12. CITIZEN OF WHAT COUNTRY?                                   |
| 13. FATHER'S NAME<br>Karl Vogl  |                  | 14. MOTHER'S MAIDEN NAME<br>?   |                               | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |
| 16. SOCIAL SECURITY NO.<br>212-10-3919  |                  | 17. INFORMANT ADDRESS<br>RECORDS: BCH 4940 Eastern Avenue 21224   |                               |  |  |
| 18. 502.1 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | (A) Myocardial Infarction<br>DUE TO<br>(B) Hypertension<br>DUE TO<br>(C) Chronic Bronchitis   |                               | INTERVAL BETWEEN ONSET AND DEATH   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Asthma  |                  |   |                               |  |  |
| 19A. DATE OF OPERATION<br>2   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                               | 20A. AUTOPSY? (Yes or No)<br>Yes   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                               | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 7, 1965 to April 8, 1965, that (I) (we) last saw the deceased alive on April 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.                                 |                  |   |                               |  |  |
| 23A. SIGNATURE<br>Dr. Charles C. Carpenter  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                               | 23B. DATE SIGNED<br>April 8, 1965  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Dr. Charles C. Carpenter  |                  | 23D. ADDRESS<br>4940 Eastern Avenue 21224   |                               |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4/12/65  |                               | 24C. NAME OF CEMETERY or CREMATORY<br>Gardens of Faith   |  |
| 24D. LOCATION (City, town, or county) (State)<br>Balt. Co. Md.  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |                               |  |  |
| 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                  | 25C. FUNERAL DIRECTOR ADDRESS<br>Connelly 300 W. Ave. Balt. 21  |                               |  |  |

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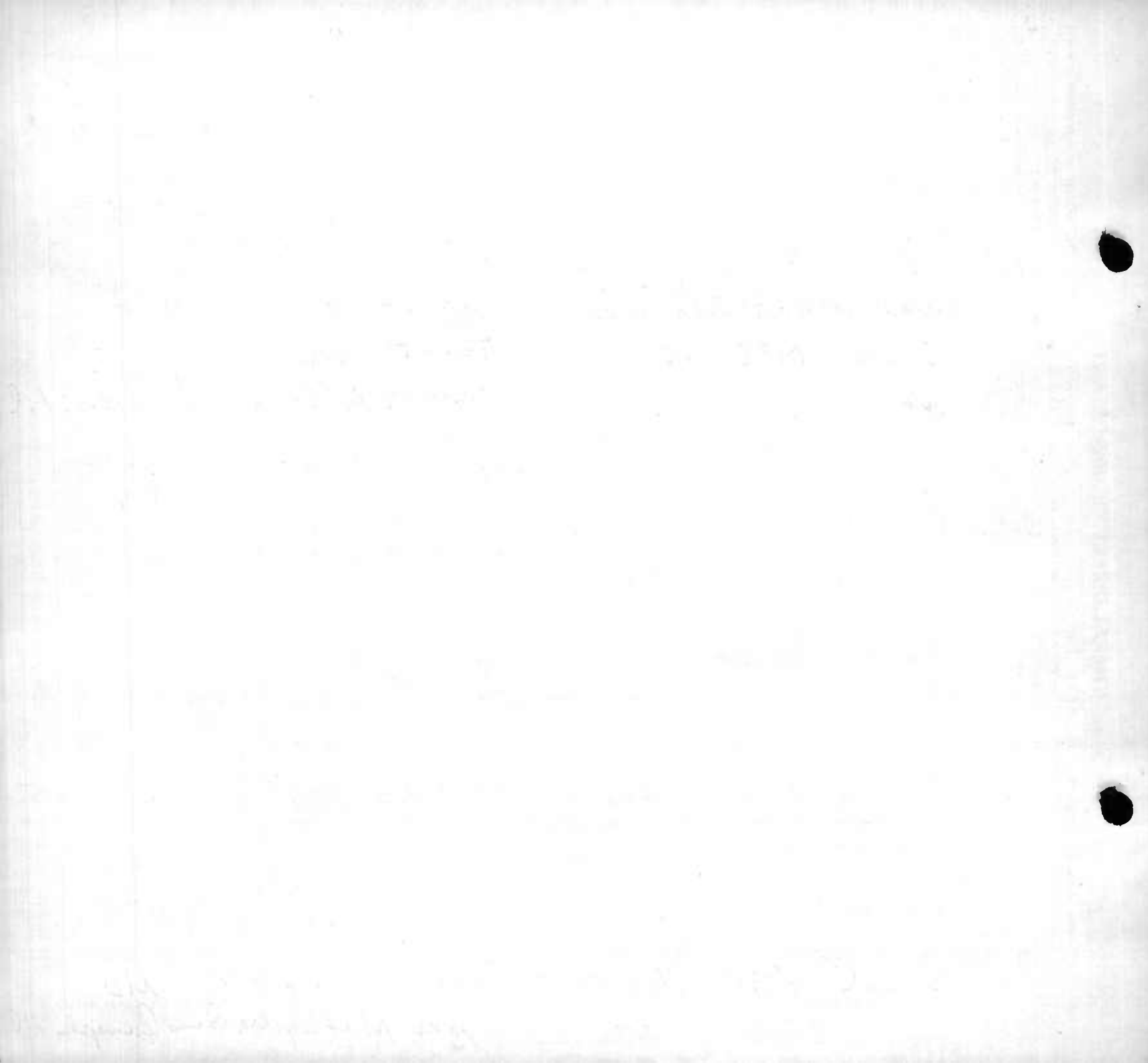
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                     |   |  |   |                                 |
|---|---------------------|---|--|---|---------------------------------|
| BIRTH NO. 65 3836   |                     | BALTIMORE CITY HEALTH DEPARTMENT  |  | REGISTERED NO. 65 3836  |                                 |
| M.E. CASE NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>ARCHIE B. McCourt</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>4/6/65 9:15 P.M.</b>  |                                 |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>ST. ANNE'S A.A. Co</b>      |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>ANNAPOLIS 52-10</b> |                                 |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Johns Hopkins Hospital</b>   |                     | D. STREET ADDRESS (If rural, give location)<br><b>319 NORTH GLEN AVE.</b>   |  | E. DATE OF BIRTH<br><b>5-21-81</b>  |                                 |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (Specify)<br><b>WIDOWED</b>  | 8. AGE (In years lost birthday)<br><b>83</b> | 9. If Under 1 Yr. Months Days   | 10. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SUPERINTENDANT BLDG. + GND</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>SCHOOL</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>SCOTLAND</b>                                      |                                 |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                     | 13. FATHER'S NAME<br><b>James McCourt</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Janet UNKL.</b>  |                                 |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                     | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>SPENCER McCourt</b>   |                                 |
| 18. <b>163X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>SEPTICEMIA</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>CHLOROMA OF THE LUNG</b> |                     | CAUSE OF DEATH<br>(A) DUE TO<br><b>CHLOROMA OF THE LUNG</b><br>(B) DUE TO<br><b>CHLOROMA OF THE LUNG</b><br>(C) DUE TO<br><b>CHLOROMA OF THE LUNG</b> |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>36 hrs</b>   |                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |   |  |   |                                 |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |                                 |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                     | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>                                     |  |   |                                 |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |                                 |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |                                 |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>2/23</b> 19 <b>65</b> to <b>4/6</b> 19 <b>65</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4/6</b> 19 <b>65</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.            |                     |   |  |   |                                 |
| 23A. SIGNATURE<br><b>Mark Silk</b>  |                     | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                  |  | 23B. DATE SIGNED<br><b>4/6/65</b>   |                                 |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MARK SILK</b>  |                     | 23D. ADDRESS<br><b>Johns Hopkins Hospital Baltimore, Md.</b>  |  |   |                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>4/10/65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>HILLCREST CEM.</b>                                       |                                 |
| 24D. LOCATION (City, town, or county) (State)<br><b>ANNAPOLIS MD.</b>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>   |  |   |                                 |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Stachurski</b>   |                     | 25C. FUNERAL DIRECTOR<br><b>John M. Taylor, Sons Annapolis, Md.</b>   |  |   |                                 |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ALEXANDER EDWARDS

2. DATE AND HOUR PRONOUNCED DEAD

April 6, 1965

3:00 P. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1016 Aisquith Street

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1016 Aisquith Street

5. SEX

Male

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

LABORER (R)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

SOUTH CAROLINA

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Robbins EDWARD S

14. MOTHER'S MAIDEN NAME

SUSIE

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give year or dates of service)

YES 10/29/17 - 5-5-19

16. SOCIAL  
SECURITY NO.

198-03-4353

17. INFORMANT

ELISE YOUNG

ADDRESS

SAVANNAH, GA.

18. 581.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Fatty metamorphosis of liver  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.Hypertensive & arteriosclerotic cardiovascular  
disease

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

REMOVAL

23B. DATE

4-9-65

23C. NAME OF CEMETERY or CREMATORY

SHAW CEM.

23D. LOCATION

(City, town, or county)

SAVANNAH

(State)

GA.

24A. DATE REC'D BY HEALTH DEPT.

APR 12 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Joseph B. Locks, Jr. 1304 N. Central Ave

ADDRESS

VALLEY FORD

PAID

NOV 2

## CERTIFICATE OF DEATH

Registered No.

65 3838

65 3838

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Earl Williams

2. DATE AND HOUR OF DEATH

April 8, 1965

9:00

P. M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 212244. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland Baltimore

C. CITY OR TOWN (If outside city limits, write RURAL and give township)  
RURAL

D. STREET ADDRESS (If rural, give location)

1600 Cape May Road 21221

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Separated

8. DATE OF BIRTH

10-20-97

9. AGE (In years  
last birthday)

67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Unknown

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Enoch Williams

14. MOTHER'S MAIDEN NAME

Elizabeth ?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

232-01-9030

17. INFORMANT

ADDRESS

RECORDS: BCH: 4940 Eastern Avenue #21224

18. 5-28X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A)  
DUE TO

Myocardial Infarction

1 Day

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B)  
DUE TO

Gastrointestinal Hemorrhage 3 Days

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
WorkNot While  
At Work

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from April 8, 19 65 to April 8, 19 65.

that (I) (we) last saw the deceased alive on April 8, 19 65 and that in (my) (our) opinion death occurred on the date

and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

April 8, 1965

23C. PHYSICIAN'S  
NAME (Type)

Dr. Charles Carpenter

M.D.

23D. ADDRESS

4940 Eastern Avenue Baltimore, Maryland #24

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4-12-1965

24C. NAME of CEMETERY or CREMATORY

Swan Pond Cemetery

24D. LOCATION

(City, town, or county)

Martinsburg, W. Va.

(State)

25A. DATE REC'D BY HEALTH DEPT.

APR 12 1965

25B. NAME OF REGISTRAR

Robert E. Taylor

25C. FUNERAL DIRECTOR

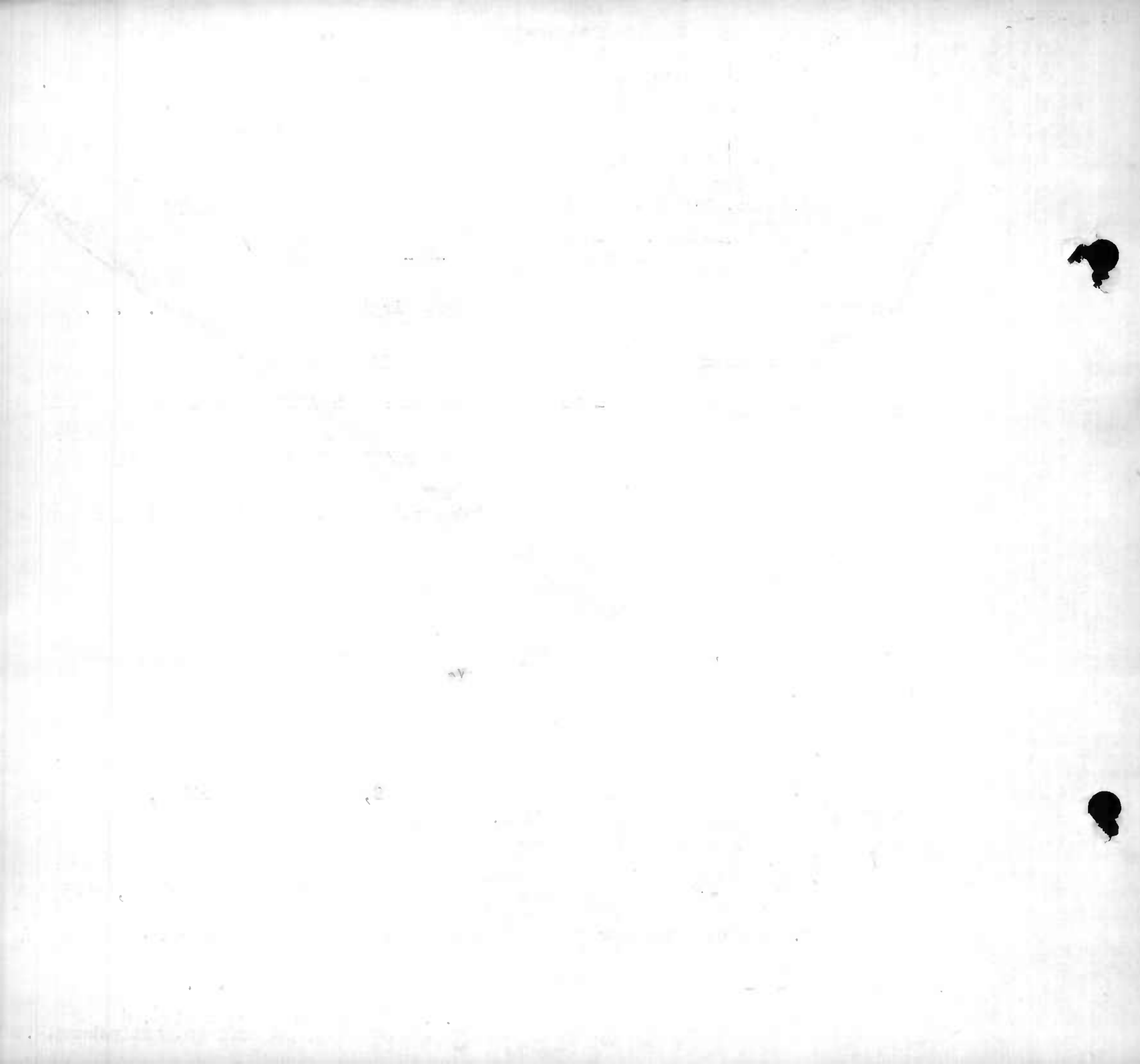
F.C. Higinbotham, Ellicott City, Md

ADDRESS

for Bogatsch and Coffman, Martinsburg, W. Va.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



|   |  |                                  |  |   |  |
|---|--|----------------------------------|--|---|--|
| BIRTH NO. 65 3839   |  | BALTIMORE CITY HEALTH DEPARTMENT |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3839  |  |
| M.E. CASE NO.   |  |                                  |  | 1. NAME OF DECEASED (Type or Print) JAMES TROGDON   |  |
| 2. DATE AND HOUR PRONOUNCED DEAD 4/8/65 9:50 p. M.  |  |                                  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD South Baltimore General  |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) Maryland  |  |                                  |  | 5. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore  |  |
| 6. STREET ADDRESS (If rural, give location) 1296 Riverside Ave.   |  |                                  |  | 7. SEX male   |  |
| 8. RACE white   |  |                                  |  | 9. MARIED, NEVER MARIED WIDOWED, DIVORCED (Specify) married   |  |
| 10. DATE OF BIRTH June 4, 1913  |  |                                  |  | 11. AGE (In years lost birthday) 51 yrs.  |  |
| 12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver   |  |                                  |  | 13. KIND OF BUSINESS OR INDUSTRY Interstate   |  |
| 14. BIRTHPLACE (State or foreign country) Greensboro N. Carolina U.S.A.   |  |                                  |  | 15. CITIZEN OF WHAT COUNTRY? U.S.A.   |  |
| 16. FATHER'S NAME Hubert Henry Trogdon  |  |                                  |  | 17. MOTHER'S MAIDEN NAME Lena Pullum  |  |
| 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes W.W. II   |  |                                  |  | 19. SOCIAL SECURITY NO. 246-09-2749   |  |
| 20. INFORMANT Carlos B. Trogdon   |  |                                  |  | 21. ADDRESS 1296 Riverside Ave.   |  |
| 22. CAUSE OF DEATH Myocardial infarction  |  |                                  |  | 23. INTERVAL BETWEEN ONSET AND DEATH  |  |
| 24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) thrombosis of coronary artery |  |                                  |  | 25. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  |
| 26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                                  |  | 27. MEDICAL CERTIFICATION   |  |
| 28. DATE OF OPERATION 4/20/65   |  |                                  |  | 29. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 30. AUTOPSY? (Yes or No) yes  |  |                                  |  | 31. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes   |  |
| 32. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.   |  |                                  |  | 33. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)  |  |
| 34. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |                                  |  | 35. HOW DID INJURY OCCUR?   |  |
| 36. TIME OF INJURY (APPROX.)  |  |                                  |  | 37. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK   |  |
| 38. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner   |  |                                  |  | 39. CHIEF MEDICAL EXAMINER  |  |
| 40. ACTUAL SIGNATURE W.U. Spitz, M.D.   |  |                                  |  | 41. DATE SIGNED 4/9/65  |  |
| 42. BUREAU OF CREMATION, REMOVAL (Specify) Burial   |  |                                  |  | 43. DATE 4/12/65  |  |
| 44. NAME OF CEMETERY or CREMATORY Lake View Memorial Pk.  |  |                                  |  | 45. LOCATION (City, town, or county) Greensboro N. Carolina   |  |
| 46. DATE REC'D BY HEALTH DEPT. APR 12 1965  |  |                                  |  | 47. NAME OF REGISTRAR Robert E. Fairbank  |  |
| 48. FUNERAL DIRECTOR KRAUSE FUNERAL HOME  |  |                                  |  | 49. ADDRESS 1216 S. Charles St  |  |



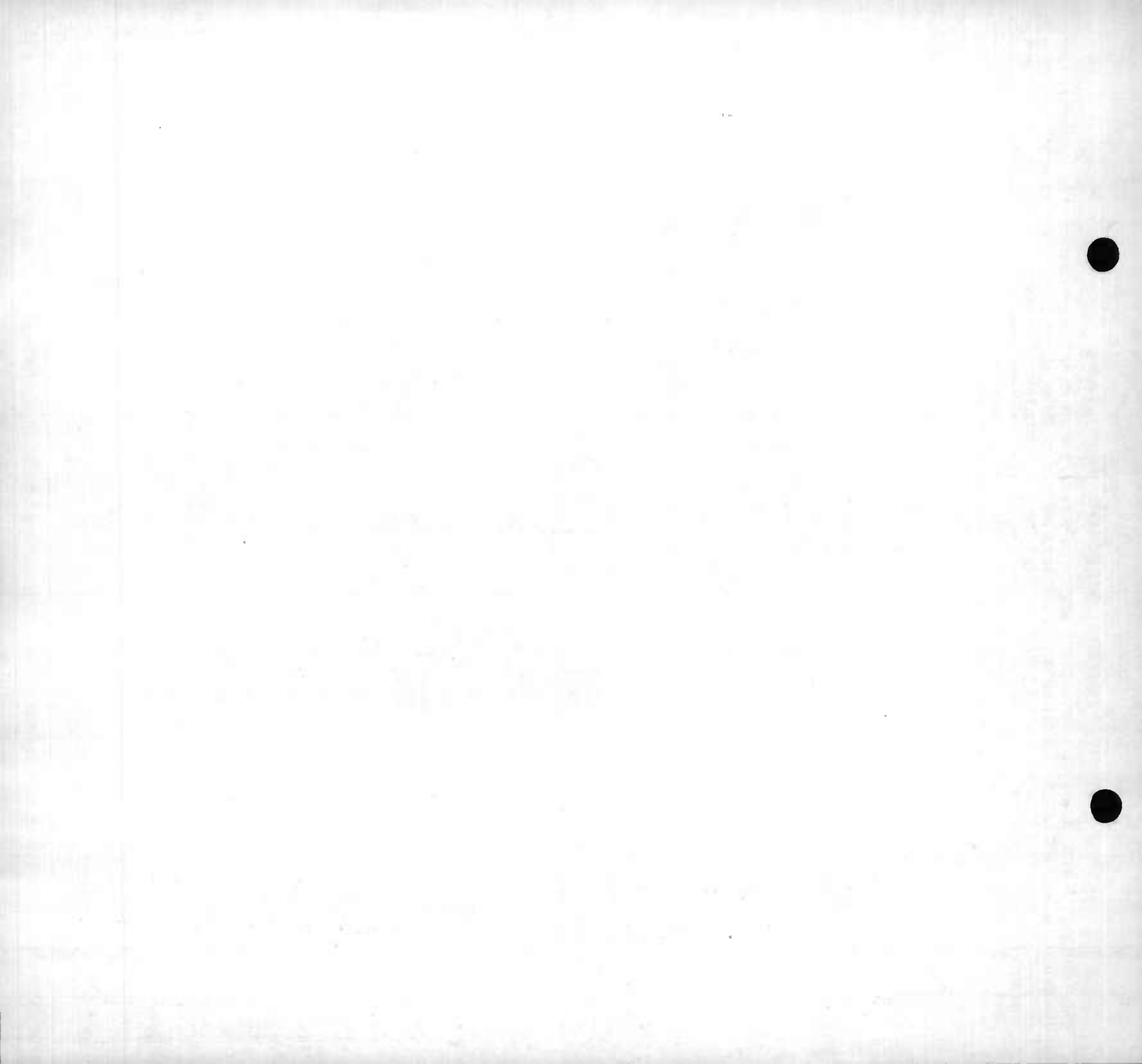




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

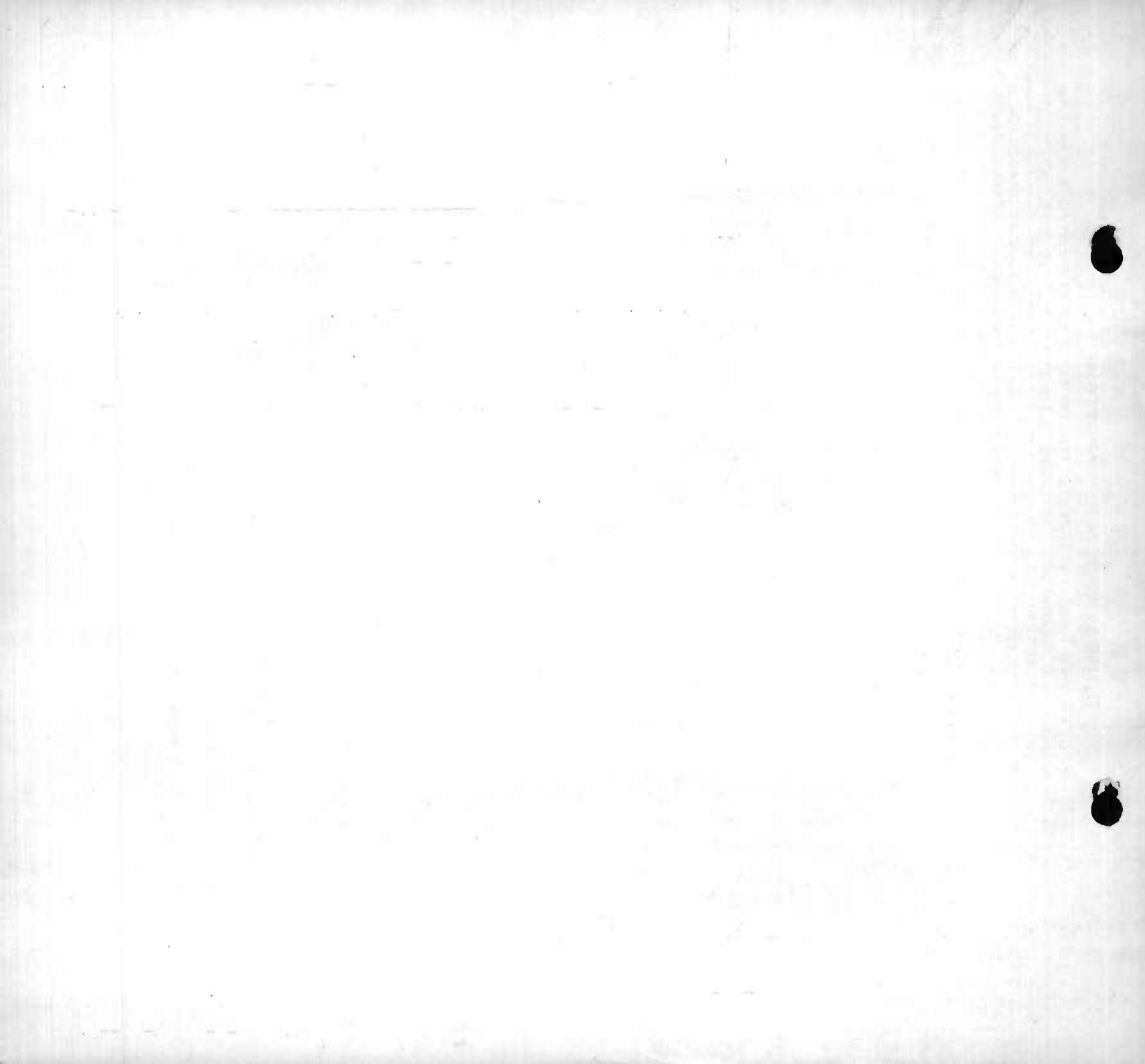
| BIRTH NO. 65 3840  |                     |   |                                    | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3840   |                       |
|--|---------------------|---|------------------------------------|---|--|--|-----------------------|
| M.E. CASE NO.  |                     |   |                                    | CERTIFICATE OF DEATH  |  |  |                       |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Linwood Ransom</u>   |                     |   |                                    | 2. DATE AND HOUR OF DEATH<br><u>4/8/65</u> <u>2:05</u> A.M.   |  |  |                       |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |  |                       |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Montebello State Hospital</u>   |                     | (If not in hospital or institution, give street address or location)                                      |                                    | A. STATE<br><u>Maryland</u>   |  | B. COUNTY<br><u>6-04</u>   |                       |
|  |                     |   |                                    | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>Baltimore</u>                                     |  |  |                       |
|  |                     |   |                                    | D. STREET ADDRESS (If rural, give location)<br><u>134 N. Chapel Street</u>  |  |  |                       |
| 5. SEX<br><u>M</u>   | 6. RACE<br><u>C</u> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><u>married</u>                                | 8. DATE OF BIRTH<br><u>10/6/11</u> | 9. AGE (in years lost birthday)<br><u>54</u>  | If Under 1 Yr. Months: Days: Hours: Min. |  | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Goodwill</u>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>                          |                       |
| 13. FATHER'S NAME<br><u>William Ransom</u>   |                     |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Virginia Bangh</u>   |  |  |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>  |                     | 16. SOCIAL SECURITY NO.<br><u>-</u>   |                                    | 17. INFORMANT<br><u>Mrs. Linwood Ransom</u>   |  | ADDRESS<br><u>1627 E. Lansing</u>                                    |                       |
| 18. <u>163 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><u>pulmonary congestion</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>carcinoma of lung</u><br>CAUSE OF DEATH<br>(A) <u>pulmonary congestion</u> DUE TO<br>(B) <u>carcinoma of lung</u> DUE TO<br>(C) <u>5 months</u> |                     |   |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><u>5 months</u>   |  |  |                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><u>paraplegic - metastases</u>  |                     |   |                                    |   |  |  |                       |
| 19A. DATE OF OPERATION<br><u>0</u>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?  |  |  |                       |
| 22. I certify that (I) (this hospital) attended the deceased from <u>12/1/14</u> 19 <u>64</u> to <u>4/8</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                     |   |                                    |   |  |  |                       |
| 23A. SIGNATURE<br><u>Robert W. Ireland</u> M.D.  |                     |   |                                    | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED<br><u>4/8/65</u>                                    |                       |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Robert W. Ireland</u> M.D.  |                     |   |                                    | 23D. ADDRESS<br><u>Montebello State Hosp.</u>   |  |  |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                     | 24B. DATE<br><u>4-12-65</u>   |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><u>Mt Auburn Cem</u>  |  | 24D. LOCATION (City, town, or county) (State)<br><u>Balto Md</u>     |                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 12 1965</u>  |                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Ireland</u>  |                                    | 25C. FUNERAL DIRECTOR<br><u>Rayner Sanders</u>  |  | ADDRESS<br><u>217 E. Preston St</u>                                  |                       |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

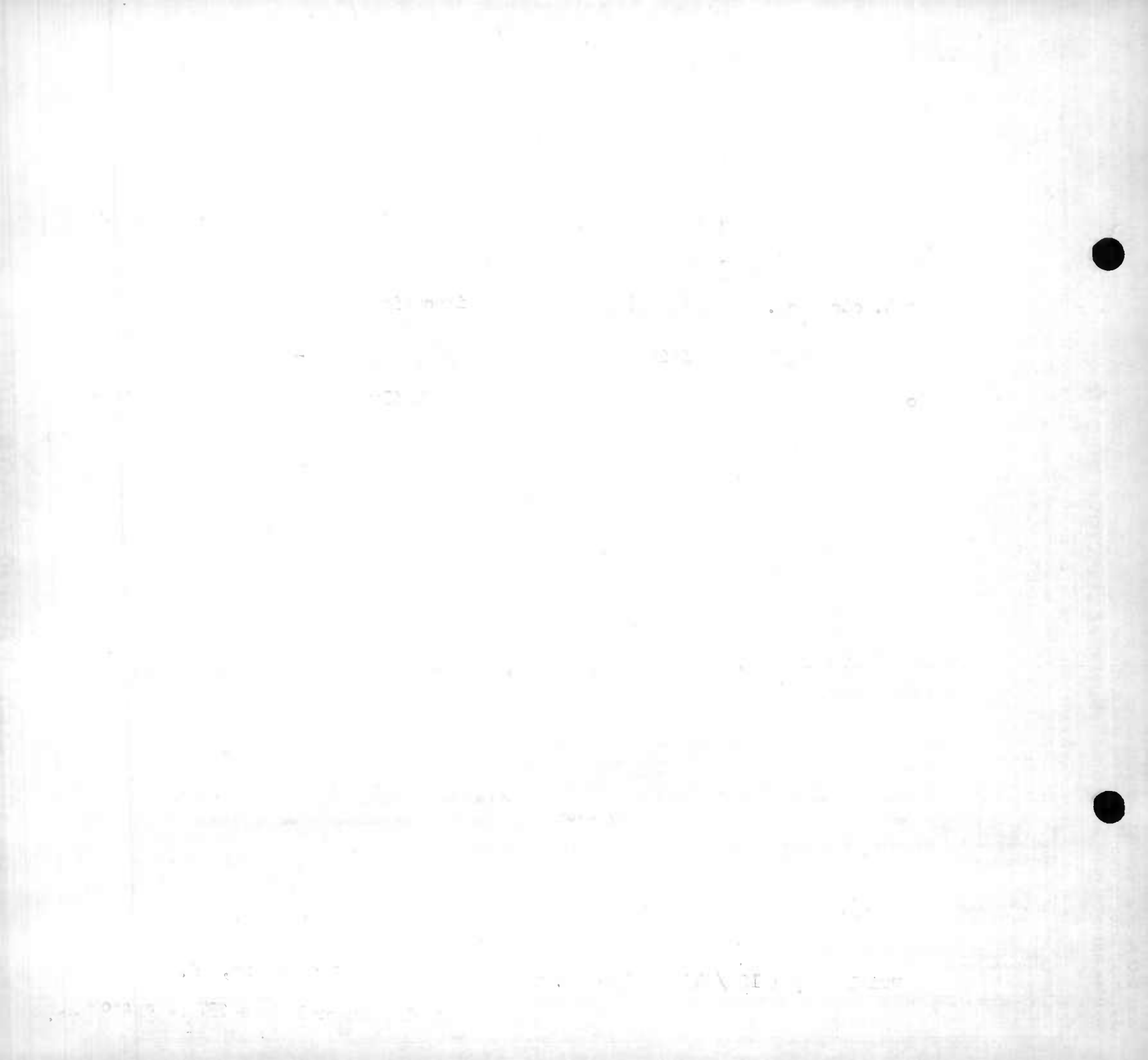
| BALTIMORE CITY HEALTH DEPARTMENT  |                        |   |   | Registered No.                        |  |
|---|------------------------|---|---|---------------------------------------|--|
| BIRTH NO.<br>65 3841  |                        | 65 3841   |   | CERTIFICATE OF DEATH                  |  |
| M.E. CASE NO.   |                        | 1. NAME OF DECEASED<br>(Type or Print)  |   | 2. DATE AND HOUR OF DEATH             |  |
|   |                        | MISS CARRIE CHRISTINE ALGIRE  |   | April-9-1965 15 P.M. M.               |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                        | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                     |   |                                       |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)  |                        | A. STATE<br>Maryland, Baltimore City  |   |                                       |  |
| 531 Woodbourne Avenue   |                        | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore (21212)              |   |                                       |  |
|   |                        | D. STREET ADDRESS (If rural, give location)<br>531 Woodbourne Ave. - 21212                                |   |                                       |  |
| 5. SEX<br>Female  | 6. RACE<br>White       | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Never Married                                 | 8. DATE OF BIRTH<br>July-28-1894  | 9. AGE (In years last birthday)<br>70 | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>retired  |                        | 10B. KIND OF BUSINESS OR INDUSTRY<br>Md. Natl. Bank.  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Md.   |                                       | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                                 |
| 13. FATHER'S NAME<br>JOHN JACOB ALGIRE  |                        |   | 14. MOTHER'S MAIDEN NAME<br>LUCY CANOLES  |                                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no  |                        | 16. SOCIAL SECURITY NO.<br>215-18-2127A   | 17. INFORMANT ADDRESS<br>C.W. Algire (brother) 4730 Dunkirk Rd-21228  |                                       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>420.14 260X<br>ANTCEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                        |   | CAUSE OF DEATH<br>(A) DUE TO<br>Coronary artery Disease<br>(B) DUE TO<br>Arteriosclerotic Cardiovascular Disease<br>(C) _____ |                                       | INTERVAL BETWEEN ONSET AND DEATH<br>many years                       |
| 19A. DATE OF OPERATION  |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  | 20A. AUTOPSY? (Yes or No)   |                                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                       |  |
| 21D. TIME OF INJURY (APPROX.)<br>1 Month) (Day) (Year) (Hour)   |                        | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |                                       |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4-24 1962 to 4-9 1965, that (I) (we) last saw the deceased alive on 3-27 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                        |   |   |                                       |  |
| 23A. SIGNATURE<br>Max R. English M.D.   |                        |   | 23B. DATE SIGNED<br>4-10-65   |                                       |  |
| 23C. PHYSICIAN'S NAME (Type)  |                        |   | 23D. ADDRESS  |                                       |  |
| Max R. English M.D.   |                        |   | 5713 Belair Rd Baltimore 6 Md   |                                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>burial  | 24B. DATE<br>Apr-12-65 | 24C. NAME of CEMETERY or CREMATORY<br>London Park   | 24D. LOCATION (City, town, or county) (State)<br>Baltimore Md. 21229  |                                       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |                        | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  | 25C. FUNERAL DIRECTOR ADDRESS<br>Staten & Co. 108-W-North-Av--1.  |                                       |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |         |  |                  |  |  |
|--|---------|--|------------------|--|--|
| BIRTH NO. 65 3842  |         | BALTIMORE CITY HEALTH DEPARTMENT   |                  | Registered No. 65 3842   |  |
| M.E. CASE NO.  |         | CERTIFICATE OF DEATH   |                  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |         | 2. DATE AND HOUR OF DEATH  |                  |  |  |
| Albert G. Gisin  |         | 4-8-65 7:25 P.M.   |                  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |         | A. STATE B. COUNTY   |                  |  |  |
| South Baltimore General Hosp.  |         | Maryland 25-04   |                  |  |  |
|  |         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |                  |  |  |
|  |         | Baltimore # 21225.   |                  |  |  |
|  |         | D. STREET ADDRESS (If rural, give location)  |                  |  |  |
|  |         | 3442 S. Hanover St.  |                  |  |  |
| 5. SEX   | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| M.   | W.      | Married  | 6-5-07           | 57   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Dept. Motor Veh.   |         | Cashier.   |                  | Wisconsin  |  |
| 13. FATHER'S NAME  |         | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Albert Gisin   |         | Mamie.   |                  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |  |
| No   |         |  |                  | Family Same  |  |
| 18. 4-20-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |         | CAUSE OF DEATH   |                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
|  |         | Myocardial Infarction  |                  |  |  |
|  |         | Atherosclerotic Cardiovascular Disease   |                  |  |  |
| ANTECEDENT CAUSES  |         |  |                  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         |  |                  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |         |  |                  |  |  |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |  |
| 2  |         |  |                  | YES.   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |         |  |                  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |                  | 21F. HOW DID INJURY OCCUR?   |  |
|  |         |  |                  |  |  |
| 22. I certify that <del>the</del> (this hospital) attended the deceased from 2/25/65 19 to 4/8/65 19, that <del>we</del> (we) lost saw the deceased alive on 4/8/65 19 and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |  |  |
| 23A. SIGNATURE   |         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                  | 23B. DATE SIGNED   |  |
| Kermit P. Bonovich   |         |  |                  | 4-9-65.  |  |
| 23C. PHYSICIAN'S NAME (Type)   |         | 23D. ADDRESS   |                  |  |  |
| Kermit P. Bonovich   |         | So. Balto. Gen. Hosp.  |                  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| Burial   |         | 4/12/65  |                  | Glen Haven   |  |
|  |         | 24D. LOCATION (City, town, or county) (State)  |                  |  |  |
|  |         | Glen Burnie, Md.   |                  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS  |  |
| APR 12 1965  |         | Glen Haven   |                  | McCully Funeral Home 237 Patapsco Ave.                                   |  |



BIRTH NO. 65 3843 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3843

M.E. CASE NO.

|   |  |                    |  |  |  |  |  |   |  |   |  |
|---|--|--------------------|--|--|--|--|--|---|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |  | LAWRENCE E. TRACEY |  | 2. DATE AND HOUR PRONOUNCED DEAD<br>April 8, 1965  |  | 2:35 A.M.  |  |   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br>44 Union Memorial Hospital   |  |                    |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY<br>C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>3701 Elm Avenue |  |  |  |   |  |   |  |
| 5. SEX<br>White   |  | 6. RACE<br>Male    |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married  |  | 8. DATE OF BIRTH<br>March 14, 1915                       |  | 9. AGE (In years<br>last birthday)<br>50  |  | If Under 1 Yr. If Under 24 Hrs.<br>Months Days Hours Min.                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Warehouse Employee   |  |                    |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Distillery  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>James W. Tracey  |  |                    |  | 14. MOTHER'S MAIDEN NAME<br>Grace V. Sprinkle  |  |  |  | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>Yes WW II |  |   |  |
| 16. SOCIAL SECURITY NO.<br>219 07 1552  |  |                    |  | 17. INFORMANT<br>Mrs. Ethel J. Tracey, 3701 Elm Ave., Balto. Md.   |  |  |  | ADDRESS   |  |   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Arteriosclerotic Cardiovascular Disease.<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |                    |  |  |  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| MEDICAL CERTIFICATION   |  |                    |  |  |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br>2   |  |                    |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20A. AUTOPSY? (Yes or No)<br>Yes  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |  |                    |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  |                    |  | 21E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: Charles S. Petty, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type): Charles S. Petty, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 4/8/65 |  |                    |  |  |  |  |  |   |  |   |  |
| 23A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  |                    |  | 23B. DATE<br>12 Apr. 65  |  | 23C. NAME of CEMETERY or CREMATORY<br>Lorraine Park Cem. |  | 23D. LOCATION (City, town, or county) (State)<br>Baltimore Co. Md.  |  |   |  |
| 24A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |  |                    |  | 24B. NAME OF REGISTRAR<br>Robert E. Feltz  |  |  |  | 24C. FUNERAL DIRECTOR<br>Burge Funeral Home, 3631 Falls Rd. Balto. Md.<br>Walter F. Burge                               |  |   |  |

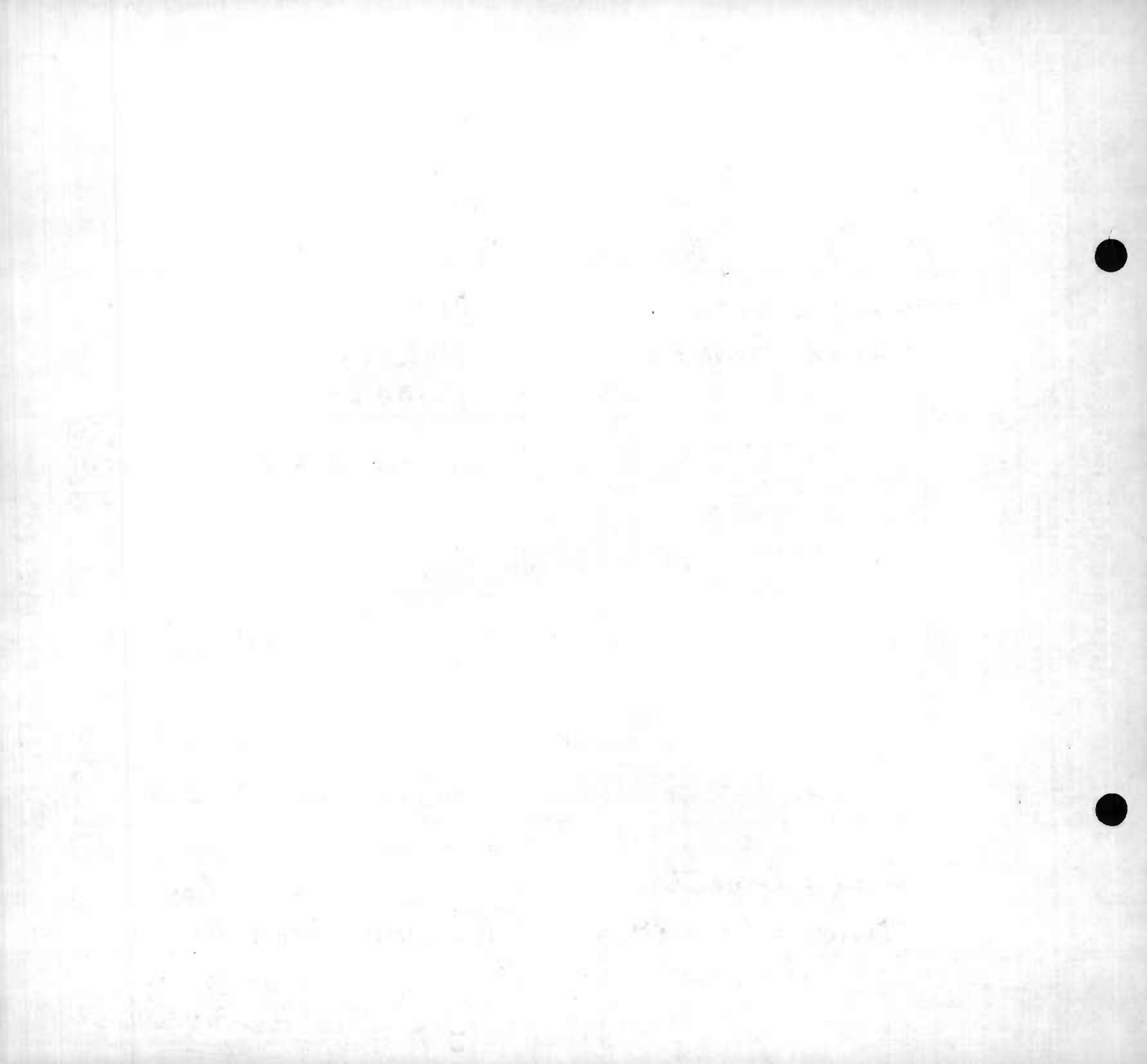
VALLEY OF THE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

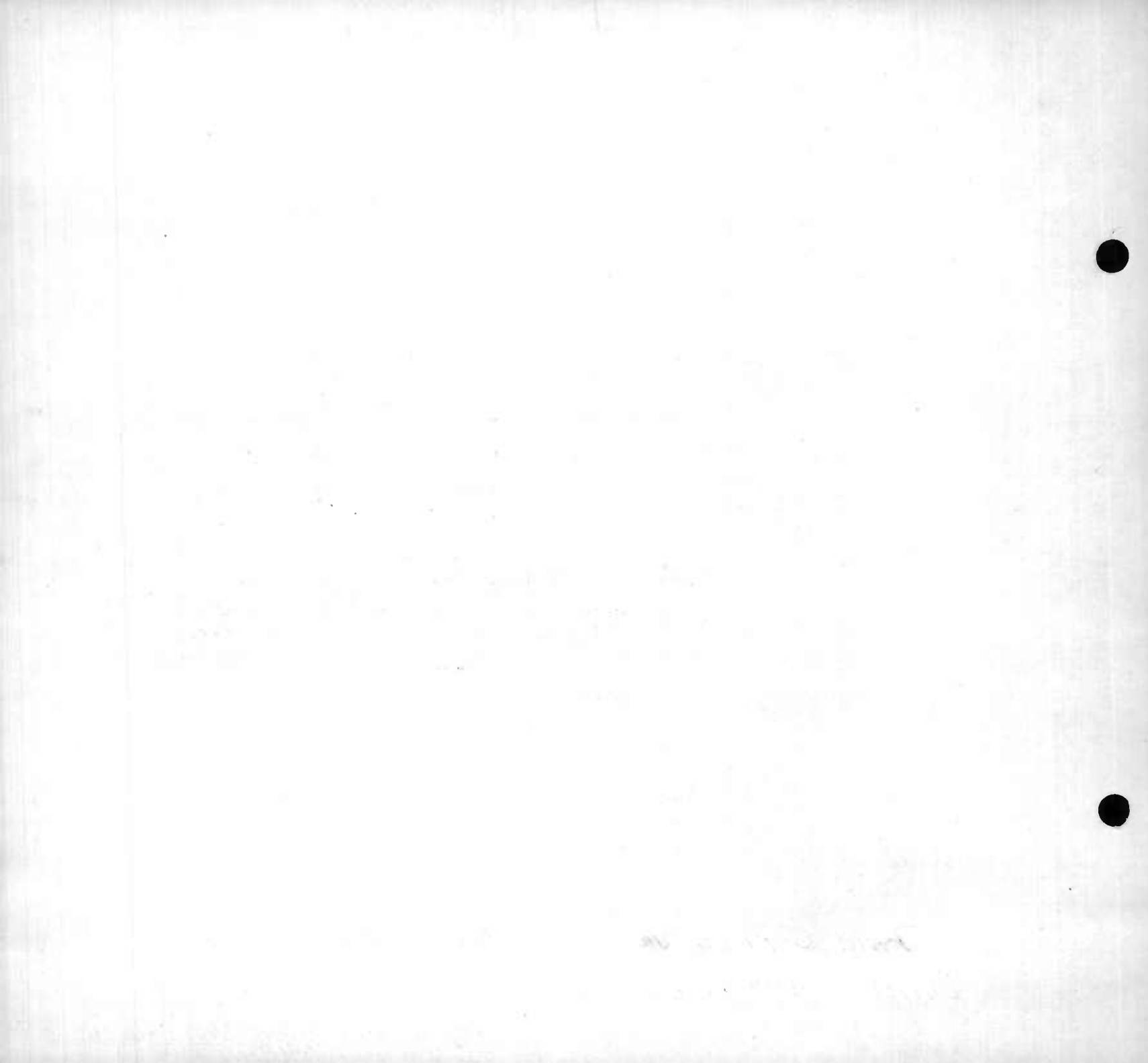
| BIRTH NO. 65 3844   |           |  |                             | BALTIMORE CITY HEALTH DEPARTMENT  |                            | Registered No. 65 3844   |                             |
|---|-----------|--|-----------------------------|---|----------------------------|--|-----------------------------|
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) LILLIAN P. HILL   |           |  |                             | 2. DATE AND HOUR OF DEATH APR. 9, 1965 10:40 P.M.                                       |                            |  |                             |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |           |  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                            |  |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL   |           |  |                             | A. STATE MD. B. COUNTY  |                            |  |                             |
|   |           |  |                             | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE 13-81 |                            |  |                             |
|   |           |  |                             | D. STREET ADDRESS (If rural, give location) 802 UNION AVE.                              |                            |  |                             |
| 5. SEX F  | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED                               | 8. DATE OF BIRTH 11-14-1900 | 9. AGE (In years lost birthday) 64  | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cotton mill Weaver  |           | 10B. KIND OF BUSINESS OR INDUSTRY Cotton Mill  |                             | 11. BIRTHPLACE (State or foreign country) MD.   |                            | 12. CITIZEN OF WHAT COUNTRY? U.S.                                    |                             |
| 13. FATHER'S NAME FRANK GRIMES  |           |  |                             | 14. MOTHER'S MAIDEN NAME HARTLEY  |                            |  |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No   |           |  |                             | 16. SOCIAL SECURITY NO. 213-05-0406   |                            | 17. INFORMANT HUSBAND ADDRESS  |                             |
| 18. 491 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |           |  |                             | (A) BRONCHOPNEUMONIA DUE TO   |                            | INTERVAL BETWEEN ONSET AND DEATH 7 DAYS                              |                             |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |           |  |                             | (B) DUE TO  |                            |  |                             |
| (C) DUE TO  |           |  |                             |   |                            |  |                             |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. RHEUMATOID ARTHRITIS  |           |  |                             |   |                            |  |                             |
| 19A. DATE OF OPERATION 0  |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                             | 20A. AUTOPSY? (Yes or No) No  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)     |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                |                            |  |                             |
| 21D. TIME OF INJURY (Approx.)   |           | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/> |                             | 21F. HOW DID INJURY OCCUR?  |                            |  |                             |
| 22. I certify that (X) (this hospital) attended the deceased from 7-21 1964 to 4-9 1965, that (X) (we) last saw the deceased alive on 4-9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |           |  |                             |   |                            |  |                             |
| 23A. SIGNATURE Irving L. Cooperstein M.D.   |           |  |                             | 23B. DATE SIGNED Apr. 9, 1965   |                            |  |                             |
| 23C. PHYSICIAN'S NAME (Type) IRVING L. COOPERSTEIN M.D.   |           |  |                             | 23D. ADDRESS MONTEBELLO STATE HOSP., BALTO. MD.   |                            |  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |           | 24B. DATE April 13-1965  |                             | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park                               |                            | 24D. LOCATION (City, town, or county) (State) Baltimore Co. Maryland |                             |
| 25A. DATE REC'D BY HEALTH DEPT. APR 12 1965   |           | 25B. NAME OF REGISTRAR R. B. E. Fairbank   |                             | 25C. FUNERAL DIRECTOR Burge Funeral Home - 3631 Falls Road                              |                            | ADDRESS  |                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3845  |           |  |                          | BALTIMORE CITY HEALTH DEPARTMENT   |                              | Registered No. 65 3845   |  |
|--|-----------|--|--------------------------|--|------------------------------|--|--|
| M.E. CASE NO. 65 3845  |           |  |                          | CERTIFICATE OF DEATH   |                              |  |  |
| 1. NAME OF DECEASED (Type or Print) Lucabaugh, Lulu S.   |           |  |                          | 2. DATE AND HOUR OF DEATH April 10 1965 6:30 P.M.  |                              |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |           |  |                          | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                              |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 44 Union Memorial Hospital   |           |  |                          | A. STATE MARYLAND B. COUNTY Baltimore  |                              |  |  |
|  |           |  |                          | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Sparks 5300  |                              |  |  |
|  |           |  |                          | D. STREET ADDRESS (If rural, give location) 25 BELLCLAIR   |                              |  |  |
| 5. SEX F   | 6. RACE W | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) widowed  | 8. DATE OF BIRTH 8/30/79 | 9. AGE (In years last birthday) 85   | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |           | 10B. KIND OF BUSINESS OR INDUSTRY  |                          | 11. BIRTHPLACE (State or foreign country) MARYLAND   |                              | 12. CITIZEN OF WHAT COUNTRY? America                                 |  |
| 13. FATHER'S NAME JOSEPH E. Smith  |           |  |                          | 14. MOTHER'S MAIDEN NAME ANN GLOSS   |                              |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No  |           | 16. SOCIAL SECURITY NO.  |                          | 17. INFORMANT (Daughter) Mrs Elizabeth Rogers  |                              | ADDRESS 25 Bellclair Circle Sparks, Maryland                         |  |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |           |  |                          | CAUSE OF DEATH   |                              |  |  |
| ANTECEDENT CAUSES  |           |  |                          | INTERVAL BETWEEN ONSET AND DEATH   |                              |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |           |  |                          | (A) DUE TO Calcific coronary arteriosclerosis many years. (B) DUE TO Extensive subendocardial myocardial infarction, left ventricle & bundle about 1 week of this. (C) Prolonged shock & early small & large bowel infarction. |                              |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. Lesser sac & perisplenic abscess, walled off. Pulmonary edema & congestion   |           |  |                          |  |                              |  |  |
| 19A. DATE OF OPERATION R   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          | 20A. AUTOPSY? (Yes or No) YES  |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                              |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                          | 21F. HOW DID INJURY OCCUR?   |                              |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 9 1965 to April 10 1965, that (I) (we) last saw the deceased alive on April 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |  |                          |  |                              |  |  |
| 23A. SIGNATURE David C Prieto Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |           |  |                          | 23B. DATE SIGNED April 10, 1965  |                              |  |  |
| 23C. PHYSICIAN'S NAME (Type) David C Prieto Jr.  |           |  |                          | 23D. ADDRESS Union Memorial Hospital   |                              |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |           | 24B. DATE 4-14-65  |                          | 24C. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery  |                              | 24D. LOCATION (City, town, or county) (State) Balto. Co., Md         |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 12 1965  |           | 25B. NAME OF REGISTRAR Robert E. Johnson   |                          | 25C. FUNERAL DIRECTOR Burial Funeral Home  |                              | ADDRESS 3630 Falls Rd Balto  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |  |                                  |  |   |
|---|------------------|--|----------------------------------|--|---|
| BIRTH NO. 65 3846   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |                                  | Registered No. 65 3846   |   |
| M.E. CASE NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) MRS. BERTIE LEE McCARTIN  |                                  | 2. DATE AND HOUR OF DEATH<br>April 9, 1965 11.30 A. M.                   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>815 West 38th Street   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY 13-07<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>815 West 38th Street |                                  |  |   |
| 5. SEX<br>Female  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br>Married  | 8. DATE OF BIRTH<br>May 11, 1887 | 9. AGE (In years last birthday)<br>77                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>At Home  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    | 12. CITIZEN OF WHAT COUNTRY?<br>U S A                     |
| 13. FATHER'S NAME<br>Joseph Wilson  |                  | 14. MOTHER'S MAIDEN NAME<br>Jenny Knapp  |                                  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |                  | 16. SOCIAL SECURITY NO.<br>-----   |                                  | 17. INFORMANT<br>Charles L. McCartin 6014 Alta Avenue 6                  |   |
| 18. 420.0 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                  | CAUSE OF DEATH<br>(A) DUE TO<br>Arteriosclerosis of Heart Dis<br>(B) DUE TO<br>Malnutrition<br>(C) _____   |                                  | INTERVAL BETWEEN ONSET AND DEATH<br>yes.<br>yes.                         |   |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from March 20 19 65 to 4/10/65 19, that (I) (we) last saw the deceased alive on 3/10/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |  |                                  |  |   |
| 23A. SIGNATURE<br>Walter E. Karpfman  |                  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                                  | 23B. DATE SIGNED<br>4/10/65  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Walter E. Karpfman  |                  | 23D. ADDRESS<br>4331 Harford Rd  |                                  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>April 12, 1965  |                                  | 24C. NAME OF CEMETERY or CREMATORY<br>Woodlawn                           |   |
| 24D. LOCATION<br>Baltimore Co., Maryland  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965   |                                  |  |   |
| 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                  | 25C. FUNERAL DIRECTOR<br>Burgee Funeral Home 3631 Falls Road   |                                  |  |   |
| 25D. ADDRESS<br>Burgee, F. Burgee   |                  |  |                                  |  |   |



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. \_\_\_\_\_

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

WILLIE THOMAS

2. DATE AND HOUR PRONOUNCED DEAD

4/9/65 5:50 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Mercy Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

Maryland

A. STATE B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

2613 Beryl Ave.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Married

8. DATE OF BIRTH

2-25-1916

9. AGE (In years  
last birthday)

49

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Auto Mechanic

10B. KIND OF BUSINESS OR INDUSTRY

Filling Station

11. BIRTHPLACE (State or foreign country)

Clearwater, S.C.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Robert Thomas

14. MOTHER'S MAIDEN NAME

Sarah Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

248-14-7031

17. INFORMANT

Clara E. Thomas 2613 Beryl Ave (13)

ADDRESS

18. 430.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)Mitral bacterial valvulitis associated  
(A) DUE TO with septicemia

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/9/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-13-65

23C. NAME of CEMETERY or CREMATORY

Mt. Calvary Cemetery

23D. LOCATION

(City, town, or county)

(State)

Anne Arundel Co., Md.

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS



UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF THE ACTS OF VIOLENCE COMMITTED BY THE KKK

IN THE CITY OF MEMPHIS, TENNESSEE, ON APRIL 4, 1968

AT THE HOME OF THE LATE MARTIN LUTHER KING, JR.

IN THE CITY OF MEMPHIS, TENNESSEE

ON APRIL 4, 1968

AT THE HOME OF THE LATE MARTIN LUTHER KING, JR.

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IN THE CITY OF MEMPHIS, TENNESSEE

ON APRIL 4, 1968

AT THE HOME OF THE LATE MARTIN LUTHER KING, JR.

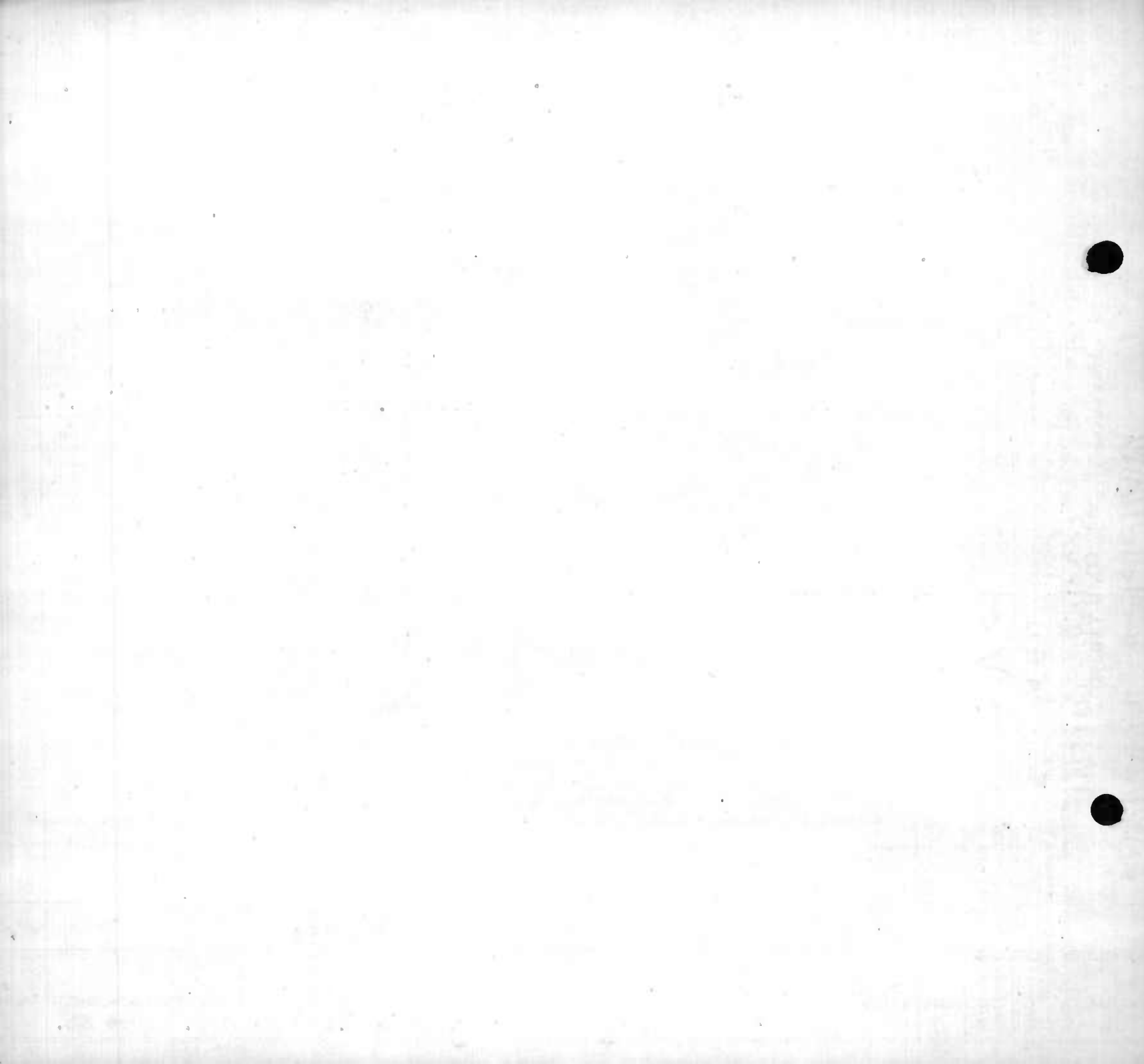
IN THE CITY OF MEMPHIS, TENNESSEE



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

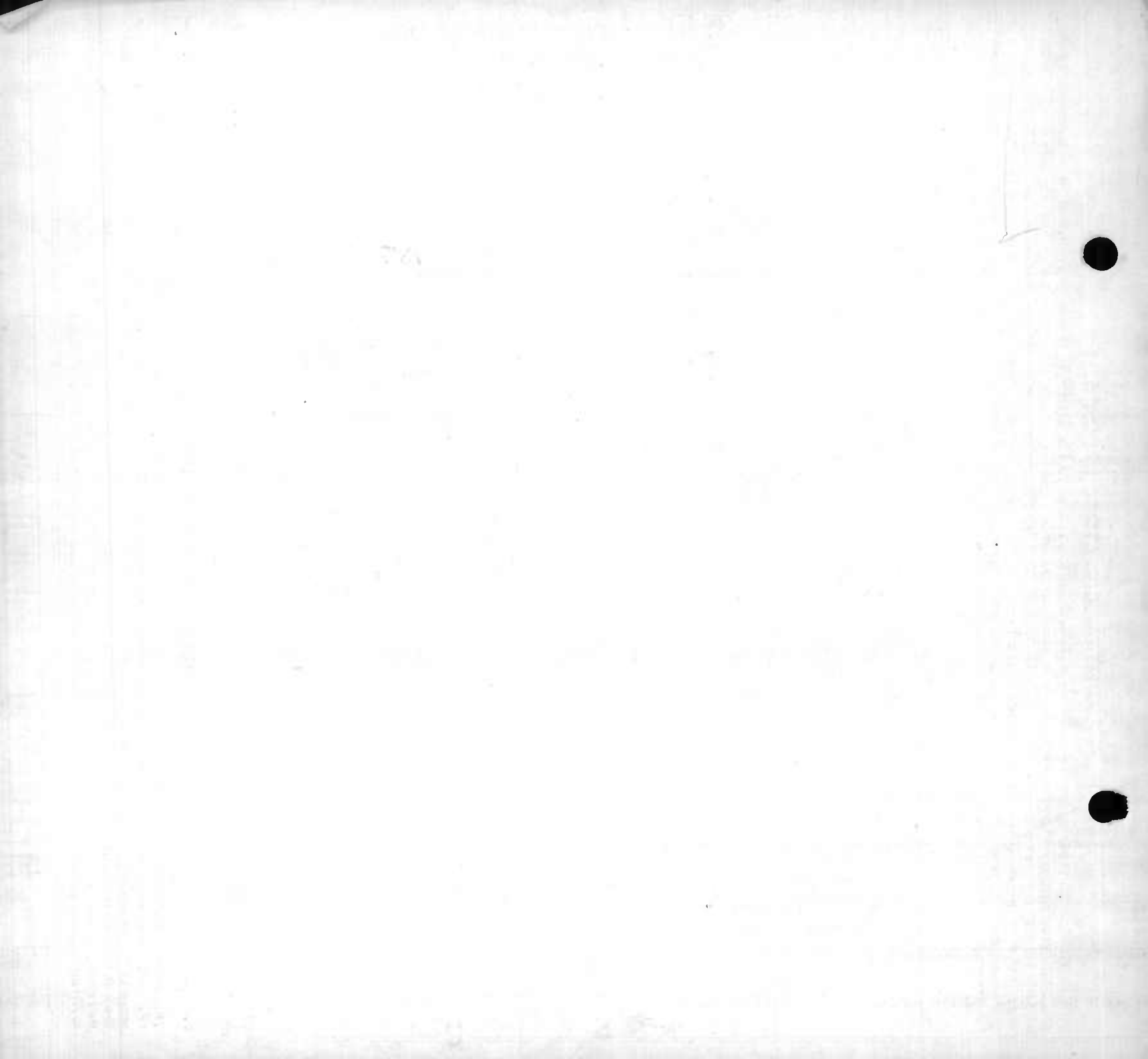
|  |                      |  |  |
|--|----------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |                      | Registered No. <b>65 3848</b>  |  |
| BIRTH NO. <b>65 3848</b>   |                      | <b>CERTIFICATE OF DEATH</b>  |  |
| M.E. CASE NO.  |                      | 2. DATE AND HOUR OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY F. PROUT (Mary F. Prout)</b>  |                      | <b>4/9/65</b> <b>14:30 A. M.</b>   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Bar- Wil- Ba Convalescent Home</b>  |                      | A. STATE <b>Maryland</b><br>B. COUNTY <b>14-03</b>   |  |
| (If not in hospital or institution, give street address or location)   |                      | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>            |  |
|  |                      | D. STREET ADDRESS (If rural, give location)<br><b>1942 Druid Hill Ave.</b>                             |  |
| 5. SEX<br><b>F.</b>  | 6. RACE<br><b>C.</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>W.</b>                                  | 8. DATE OF BIRTH<br><b>5/30/78</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Domestic</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday)<br><b>86</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                      | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME  |                      | 14. MOTHER'S MAIDEN NAME<br><b>Fannie</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                      | 16. SOCIAL SECURITY NO.  |  |
|  |                      | 17. INFORMANT<br><b>Sadie T. Brown</b> <b>709 Harris Pl. Atlantic City, N.J.</b>                       |  |
| 18. <b>422.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardio-Vascular Disease</b>   |                      | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 yrs</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                      |  |  |
| 19A. DATE OF OPERATION   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| <b>0</b>   |                      | <b>no</b>  |  |
| 20A. AUTOPSY? (Yes or No)  |                      | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                   |  |
| <b>no</b>  |                      |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  |
| <input type="checkbox"/>   |                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |
|  |                      | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Jan 1 1963</b> to <b>Apr 8 1965</b> , that (I) (we) last saw the deceased alive on <b>Apr 8 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |  |  |
| 23A. SIGNATURE<br><b>Louis A. Johnson</b>  |                      | 23B. DATE SIGNED<br><b>Apr 9-65</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr Louis A. Johnson</b>   |                      | 23D. ADDRESS<br><b>301 - E - 2224. Ba 18th</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                      | 24B. DATE<br><b>4/13/65</b>  |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Auburn</b>  |                      | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>                            |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>  |                      | 25B. NAME OF REGISTRAR<br><b>Robert E. Johnson</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Charles A. Rice</b>  |                      | ADDRESS<br><b>661 W. Barre St.</b>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |   |  |  | Registered No. <span style="font-size: 1.5em;">65 3849</span>                                     |  |
|---|---|--|--|---|--|
| BIRTH NO. <span style="font-size: 1.5em;">65 3849</span>  |   | <b>CERTIFICATE OF DEATH</b>  |  |   |  |
| M.E. CASE NO.   |   | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Patrick Dowling</span>  |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">4.10.65 5 1 15 P.M.</span>           |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><span style="font-size: 1.2em;">Little Sisters of the Poor<br/>1200 VALLEY ST.<br/>Baltimore md.</span>  |   | A. STATE <span style="font-size: 1.2em;">MD.</span><br>B. COUNTY <span style="font-size: 1.2em;">10-01</span>                        |  |   |  |
|   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.2em;">1200 VALLEY ST.</span>    |  |   |  |
|   |   | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.2em;">Baltimore md.</span>                                  |  |   |  |
| 5. SEX<br><span style="font-size: 1.2em;">M</span>  | 6. RACE<br><span style="font-size: 1.2em;">W</span>         | 7. MARRIED, NEVER MARRIED<br><span style="font-size: 1.2em;">WIDOWED</span> DIVORCED (specify)                                       |  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">8.8.1878</span>                               | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">86</span> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">LAWYER</span>  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Johnstown PA.</span> |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Patrick Dowling</span>   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">MARY MITCHELL</span>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">USA</span>                        |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No</span>   |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">_____</span>  |  | 17. INFORMANT ADDRESS<br><span style="font-size: 1.2em;">Little Sisters of the Poor</span>        |  |
| 18. <span style="font-size: 1.2em;">422.1 I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.2em;">Pulmonary edema</span>  |   | (A) DUE TO   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><span style="font-size: 1.2em;">A.S.C.V.D.</span>   |   | (B) DUE TO   |  |   |  |
|   |   | (C) <span style="font-size: 1.2em;">Generalized arteriosclerosis</span>  |  |   |  |
| <b>II</b>   |   |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   |  |  |   |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">D</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                          |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1964</span> to <span style="font-size: 1.2em;">April 10 1965</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">April 10 1965</span> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |  |   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Stanley Ankudas</span>  |   | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">4.13.65</span>                                |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Stanley Ankudas</span>  |   | 23D. ADDRESS<br><span style="font-size: 1.2em;">1802 W. BALTIMORE ST.</span>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>   | 24B. DATE<br><span style="font-size: 1.2em;">4/13/65</span> | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Cathedral</span>   |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Baltimore</span> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">APR 12 1965</span>   |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Taylor</span>  |  | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Philip Herwig Sons Orleans St</span>     |  |



BIRTH NO.

M.E. CASE NO.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

JAMES A. SEATON, SR.

2. DATE AND HOUR PRONOUNCED DEAD

April 7, 1965

11:00 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

214 S. Robinson St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

214 S. Robinson St.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)

Sep.

8. DATE OF BIRTH

Dec. 25, 1883

9. AGE (In years  
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

James Seaton (Seaton)

14. MOTHER'S MAIDEN NAME

Wilhelmina

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

212-05-8549

17. INFORMANT

Mr. James A. Seaton Jr.

ADDRESS  
5402 Summerfield Ave.

21206

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Respiratory infection

(A) ~~MYXOMA~~

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

Chronic pulmonary emphysema

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

m.

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-7-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

Apr. 9, 1965

23C. NAME of CEMETERY or CREMATORY

Baltimore Cem.

23D. LOCATION

(City, town, or county)

Balto. Md.

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 12 1965

24B. NAME OF REGISTRAR

Robert E. Taylor

24C. FUNERAL DIRECTOR

Philip's Herwig Sons

ADDRESS

2024 Orleans St. 31

WATKINS CITY HEALTH



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   | Certificate of Death   |   | Registered No. 65 3851   |  |
|---|-------------------------|---|---|--|---|--|--|
| BIRTH NO.<br>65 3851  |                         | M.E. CASE NO.   |   | 1. NAME OF DECEASED<br>(Type or Print)<br><b>JAMES MAFFEI</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>APRIL 8, 1965</b> <b>8:50 AM: DQA</b>  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>BALTIMORE CITY HOSPITAL (D.O.A.)</b>  |                         |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>DUNDALK 21222</b><br>D. STREET ADDRESS (If rural, give location)<br><b>236 BALTIMORE AVENUE</b> |   |  |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>                                | 8. DATE OF BIRTH<br><b>11/22/1890</b>                         | 9. AGE (In years last birthday)<br><b>74</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SHOEMAKER</b>   |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY                             |  | 11. BIRTHPLACE (State or foreign country)<br><b>ITALY</b> |  |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                         |   | 13. FATHER'S NAME<br><b>ANTHONY MAFFEI</b>                    |  |   | 14. MOTHER'S MAIDEN NAME<br><b>MANION (UNK.)</b>                       |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                         |   | 16. SOCIAL SECURITY NO.<br><b>219/32/0159</b>                 |  | 17. INFORMANT<br><b>ANNA T. MAFFEI AS IN #1 ABOVE</b>     |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxiation, etc. It means the disease, injury or complication which caused death.)<br><b>420.11</b><br><b>Coronary Occlusion</b><br><b>Rheumatic Carditis &amp; Aortic</b><br><b>&amp; mitral Murmurs - 50 yrs f.</b>                   |                         |   | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) <b>None</b> |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 min.</b>                      |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>II</b>   |                         |   |   |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (If in or about home, farm, factory, street, office bldg., etc.)<br><b>None</b>      |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>MAY-1963</b> 19 to <b>April 8</b> 19 <b>65</b> .<br>that (I) (we) last saw the deceased alive on <b>March 25</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |   |  |   |  |  |
| 23A. SIGNATURE<br><b>Melvin B. Davis</b>  |                         |   |   | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |   | 23B. DATE SIGNED<br><b>4/9/65</b>                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MELVIN B. DAVIS</b>  |                         |   |   | 23D. ADDRESS<br>M.D. <b>DUNDALK, MD.</b>   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>4/12/65</b>   |   | 24C. NAME of CEMETERY or CREMATORY<br><b>ST. STANISLAUS</b>  |   | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MD.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Farley</b>   |   | 25C. FUNERAL DIRECTOR<br><b>Brooks Bradley</b>   |   | ADDRESS<br><b>31 BROOKS BRADLEY, DUNDALK, MD</b>                       |  |



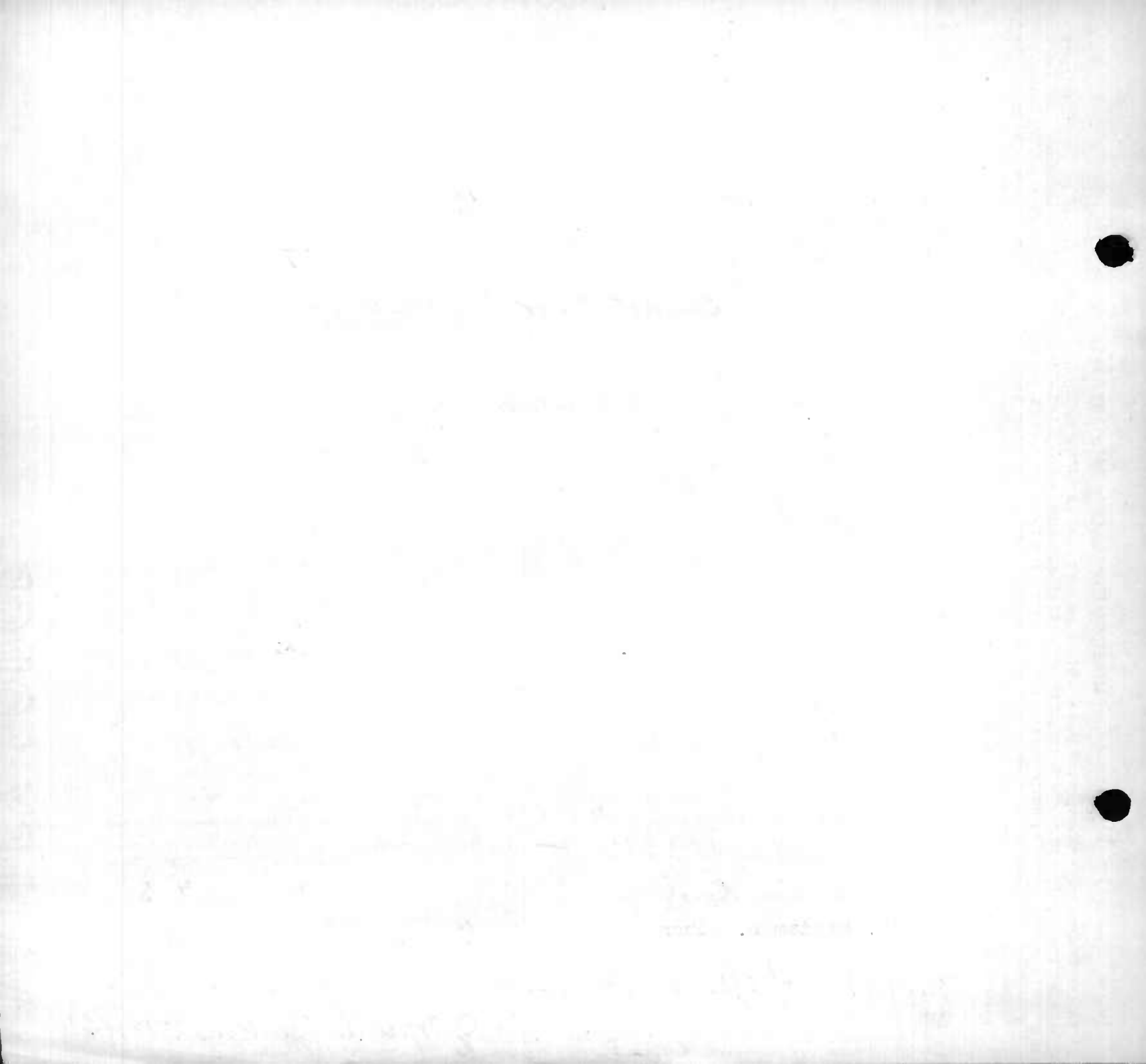




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

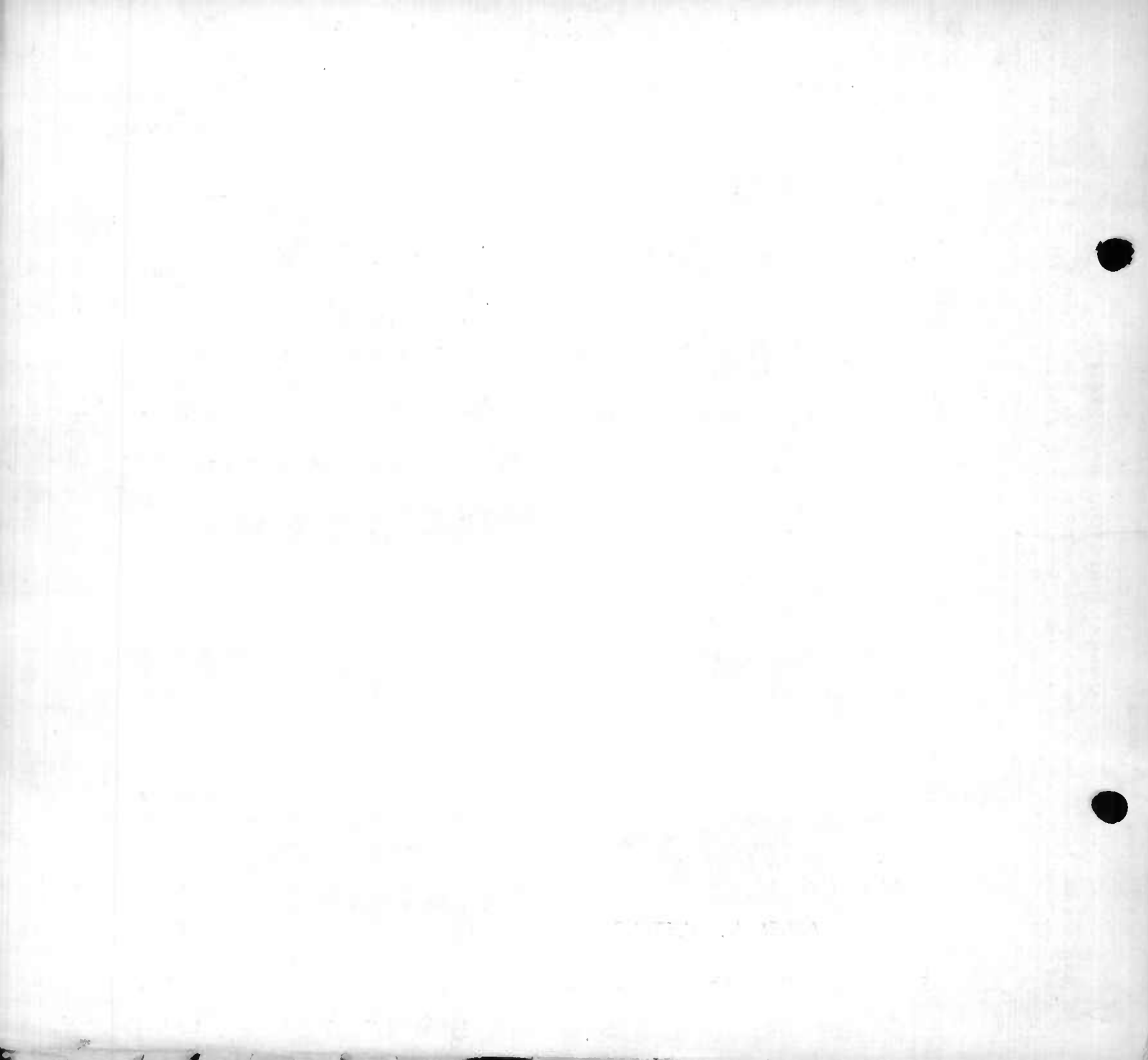
| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |                                   | BIRTH NO. 65 3852  |  | CERTIFICATE OF DEATH  |  | Registered No. 65 3852      |  |
|--|---------------------|---|-----------------------------------|--|--|---|--|-----------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Henry C. Jensen</u>  |                     |   |                                   | 2. DATE AND HOUR OF DEATH<br><u>4-8-65</u> <u>9</u> <u>17</u> M.   |  |   |  |                             |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Union Memorial Hospital</u>  |                     |   |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>9-07</u><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <u>Baltimore</u><br>D. STREET ADDRESS (If rural, give location) <u>426 Homestead Street</u> |  |   |  |                             |  |
| 5. SEX<br><u>M</u>   | 6. RACE<br><u>W</u> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><u>married</u>                                | 8. DATE OF BIRTH<br><u>4-7-88</u> |  | 9. AGE (In years lost birthday)<br><u>77</u> | If Under 1 Yr. Months Days  |  | If Under 24 Hrs. Hours Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Retired</u>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Cabinet Maker</u>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><u>Copenhagen Denmark</u>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>                            |  |                             |  |
| 13. FATHER'S NAME<br><u>unknown</u>  |                     |   |                                   | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>   |  |   |  |                             |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give wot or dates of service)   |                     | 16. SOCIAL SECURITY NO.<br><u>213-01-3104</u>   |                                   | 17. INFORMANT<br><u>Mrs. Helen Jensen</u>  |  | ADDRESS<br><u>Same -</u>  |  |                             |  |
| 18. <u>420.1 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   |                                   | (A) <u>Myocardial infarction</u><br>DUE TO   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>12 hours.</u>                  |  |                             |  |
|  |                     |   |                                   | (B) <u>Coronary occlusion</u><br>DUE TO  |  | <u>12 hours.</u>  |  |                             |  |
|  |                     |   |                                   | (C) <u>Arteriosclerosis</u>  |  | <u>years.</u>   |  |                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |   |                                   | <u>Cerebrovascular accident (L)</u>  |  |   |  |                             |  |
| 19A. DATE OF OPERATION<br><u>2</u>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)<br><u>yes</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |                             |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                   | 21F. HOW DID INJURY OCCUR?   |  |   |  |                             |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3-7-1965</u> to <u>4-7-1965</u> , that (I) (we) last saw the deceased alive on <u>4-7-1965</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                               |                     |   |                                   |  |  |   |  |                             |  |
| 23A. SIGNATURE<br><u>Miriam L. Cohen</u>   |                     |   |                                   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED<br><u>4-8-65</u>                                     |  |                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Dr. Miriam L. Cohen</u>   |                     |   |                                   | 23D. ADDRESS<br><u>Union Memorial Hospital</u>   |  |   |  |                             |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                     | 24B. DATE<br><u>4/12/65</u>   |                                   | 24C. NAME of CEMETERY or CREMATORY<br><u>Baltimore</u>   |  | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore Md.</u> |  |                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 12 1965</u>  |                     | 25B. NAME OF REGISTRAR<br><u>Robt E. Jensen</u>   |                                   | 25C. FUNERAL DIRECTOR<br><u>J. Melville Jenkins</u>  |  | ADDRESS<br><u>2713 Kirk</u>   |  |                             |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department  |         |  |  | Registered No.   |  |
|---|---------|--|--|--|--|
| BIRTH NO.   |         | 65 3853  |  | 65 3853  |  |
| M.E. CASE NO.   |         |  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  | 2. DATE AND HOUR OF DEATH  |  |  |
| Florence Wheeler Ayers  |         |  | April 6, 1965 8:00 P.M.  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                    |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)  |         |  | A. STATE B. COUNTY   |  |  |
| Union Memorial Hospital   |         |  | Pennsylvania - York  |  |  |
|   |         |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                                  |  |  |
|   |         |  | Delta  |  |  |
|   |         |  | D. STREET ADDRESS (If rural, give location)  |  |  |
|   |         |  | Main Street  |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                   | 8. DATE OF BIRTH   | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Female  | Cauc    | Widow  | 9-24-92  | 72   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Housewife   |         |  |  | Pennsylvania   |  |
| 13. FATHER'S NAME   |         |  | 12. CITIZEN OF WHAT COUNTRY?   |  |  |
| Channel William Wheeler   |         |  | United States  |  |  |
| 14. MOTHER'S MAIDEN NAME  |         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  |  |
| Sarah Watson  |         |  | No   |  |  |
| 16. SOCIAL SECURITY NO.   |         |  | 17. INFORMANT  |  |  |
| unknown   |         |  | Mrs Helen Holden   |  |  |
| 18. CAUSE OF DEATH  |         |  | ADDRESS  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |  | 8310 Edgell Rd Baltimore   |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |         |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| ANTECEDENT CAUSES   |         |  | (A) DUE TO   |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  | MYOCARDIAL INFARCTION  |  |  |
|   |         |  | (B) DUE TO   |  |  |
|   |         |  | ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE  |  |  |
|   |         |  | (C) DUE TO   |  |  |
|   |         |  |  |  |  |
| II  |         |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |  |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
| 2   |         |  |  | Yes  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|   |         |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |
| (Month) (Day) (Year) (Hour)   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3-16-65 to 4-6-65, that (I) (we) last saw the deceased alive on 4-6-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |  |  |  |
| 23A. SIGNATURE  |         |  |  | 23B. DATE SIGNED   |  |
| Charles L. Fletcher M.D.  |         |  |  | 4-6-65   |  |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |  | 23D. ADDRESS   |  |
| CHARLES L. FLETCHER M.D.  |         |  |  | Union Memorial Hospital  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| Burial  |         | 4-10-65  |  | SLATE RIDGE  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |  |
| APR 12 1965   |         | Robert E. Johnson  |  | John H. Haskins, DELTA, PA.  |  |
|   |         |  |  | ADDRESS  |  |

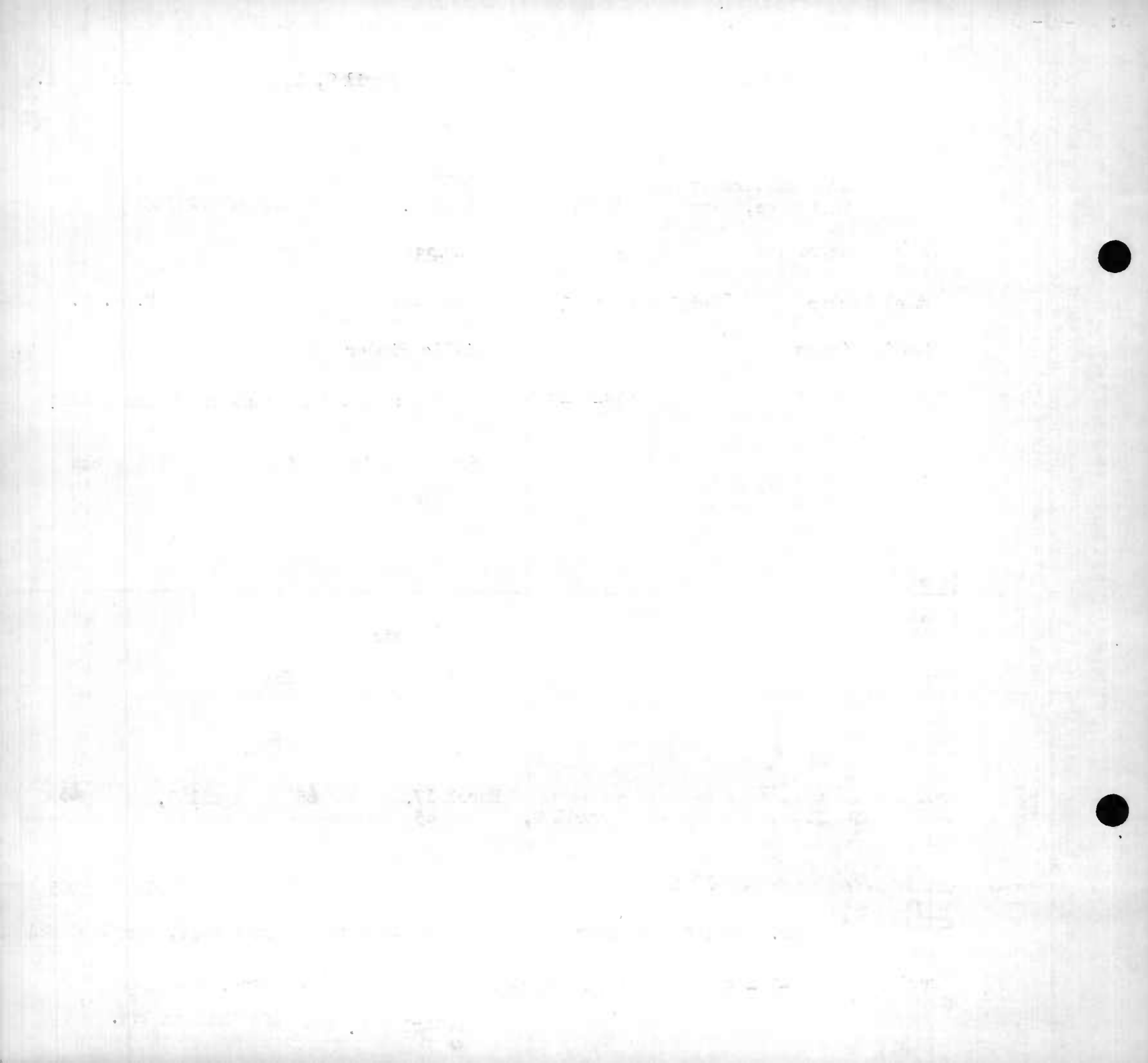


LS: 42-93-03

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

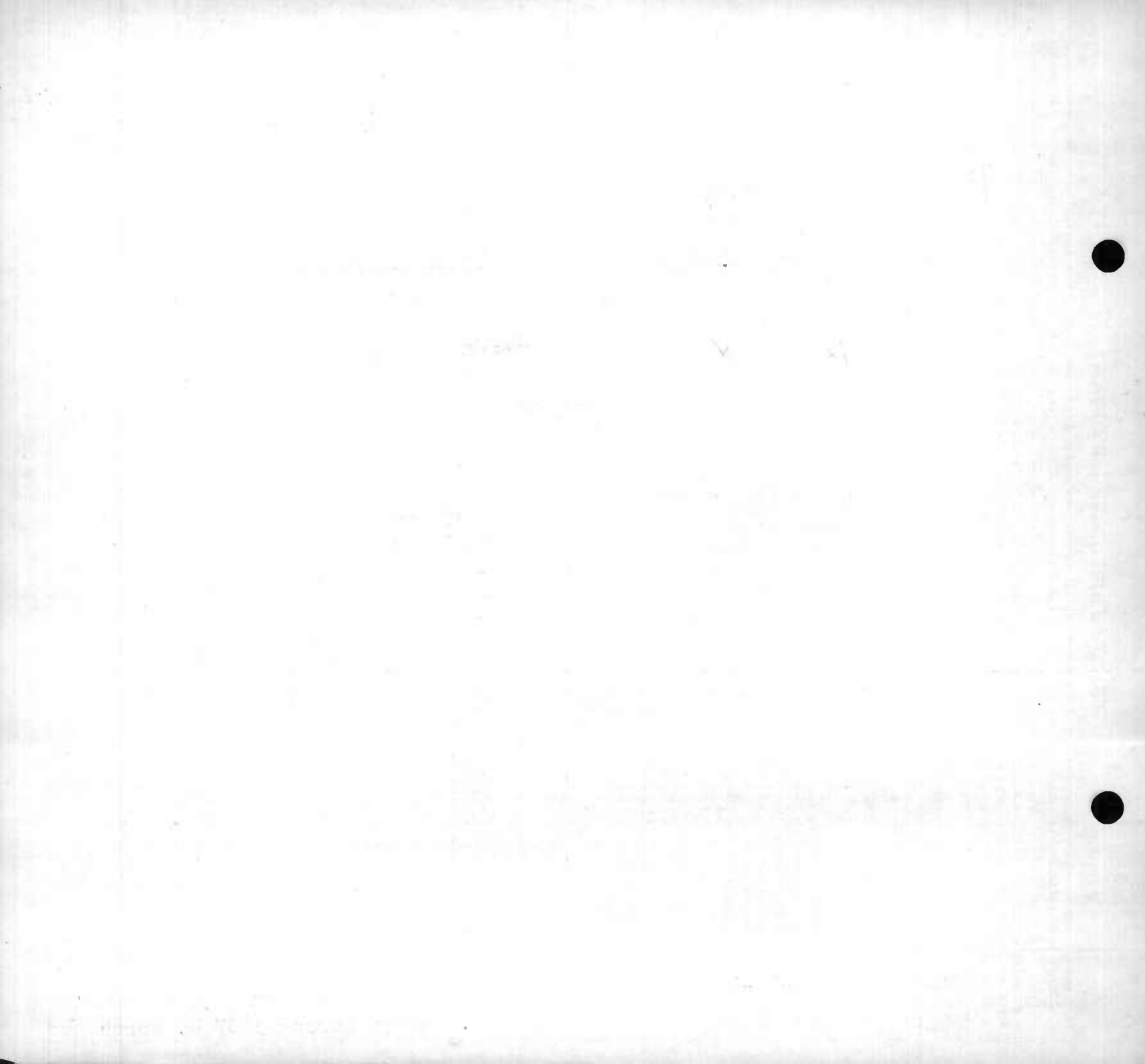
|  |  |  |  |   |  |
|--|--|--|--|---|--|
| BIRTH NO. 65 3854  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3854  |  |
| M.E. CASE NO.  |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  |   |  |
| Daniel Givens  |  | April 9, 1965  |  | 1:30 A.M.   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)     |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |  | A. STATE   |  | B. COUNTY   |  |
| Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland #21224  |  | Maryland   |  | 7-05  |  |
| 5. SEX   |  | 6. RACE  |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)  |  |
| Male   |  | Negro  |  | Single  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 8. DATE OF BIRTH  |  |
| Steel Worker   |  | Bethlehem Steel  |  | 6-7-23  |  |
| 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?   |  | 9. AGE (In years last birthday)   |  |
| Maryland   |  | U. S. A.   |  | 41  |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  | 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service) |  |
| Rannie Givens  |  | Willie Pinder  |  | Yes WW II   |  |
| 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |
| 215-14-7890  |  | RECORDS: BCH: 4940 Eastern Avenue #21224   |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) DUE TO   |  | ? 4 Weeks   |  |
| ANTECEDENT CAUSES  |  | (B) DUE TO   |  |   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (C) DUE TO   |  |   |  |
| II   |  | Metastasis   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  | 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
|  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
|  |  | Yes  |  | Yes   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                    |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |
|  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 17, 19 65 to April 9, 1965, that (I) (we) last saw the deceased alive on April 9, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE   |  |  |  | 23B. DATE SIGNED  |  |
| Dr. Charles Carpenter  |  |  |  | April 9, 1965   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |  |  | 23D. ADDRESS  |  |
| Dr. Charles Carpenter  |  |  |  | 4940 Eastern Avenue Baltimore, Maryland #24   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY  |  |
| Burial   |  | 4-13-65  |  | Baltimore National  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  |
| APR 12 1965  |  | Robert E. Taylor   |  | Charles R. Law  |  |
|  |  |  |  | 802 Madison Ave.  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital, (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                      |  |   |   |  |  |  |  |  |
|---|----------------------|--|---|---|--|--|--|--|--|
| BIRTH NO. 65 3855   |                      |  |   |   | CERTIFICATE OF DEATH   |  | Registered No. 65 3855   |  |  |
| M.E. CASE NO.   |                      |  |   |   | 1. NAME OF DECEASED<br>(Type or Print) <i>Brannan, Mrs. Annie A.</i>   |  |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><i>April 7, 1965 11:45 P.M.</i>  |                      |  |   |   |  |  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                      |  |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                          |  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Maryland General Hospital</i><br>(If not in hospital or institution, give street address or location)  |                      |  |   |   | A. STATE<br><i>Maryland</i>  |  |  |  |  |
|   |                      |  |   |   | B. COUNTY<br><i>9-08</i>   |  |  |  |  |
|   |                      |  |   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore, 18</i>                |  |  |  |  |
|   |                      |  |   |   | D. STREET ADDRESS (If rural, give location)<br><i>1002 E. 20th St.</i>   |  |  |  |  |
| 5. SEX<br><i>Female</i>   | 6. RACE<br><i>W.</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Married</i> |   | 8. DATE OF BIRTH<br><i>8-13-1877</i>                            | 9. AGE (In years last birthday)<br><i>87</i>   | If Under 1 Yr. Months Days   |  | If Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                      |  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>=                          |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U. S. A.</i>                      |  |
| 13. FATHER'S NAME<br><i>J. T. Newman</i>  |                      |  |   |   | 14. MOTHER'S MAIDEN NAME<br><i>ELENA Avery</i>   |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>no</i>   |                      |  |   | 16. SOCIAL SECURITY NO.<br><i>2109-9921</i>                     |  | 17. INFORMANT<br><i>Clarence W. Brannan</i><br><i>Husband (by phone)</i><br><i>1002 E. 20th St. Balto, Md.</i> |  |  |  |
| 18. <i>492X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      |  |   |   | CAUSE OF DEATH<br>(A) <i>Pneumonitis, Myocardial Infarction</i><br>(B) <i>Acute Heart Failure</i><br>(C) _____ |  |  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><i>About 1 month</i>  |                      |  |   |   |  |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><i>Acute Cardiac Failure.</i>   |                      |  |   |   |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                      |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20A. AUTOPSY? (Yes or No)<br><i>no</i>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                      |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                       |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                      |  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> |   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-1</i> 19 <i>65</i> to <i>4-7</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4-7</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                      |  |   |   |  |  |  |  |  |
| 23A. SIGNATURE<br><i>Ey Kol Koh</i> M.D.  |                      |  |   |   |  |  |  | 23B. DATE SIGNED<br><i>4-7-65</i>                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Ey Kol Koh</i> M.D.  |                      |  |   |   |  |  |  | 23D. ADDRESS   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Entombment</i>   |                      | 24B. DATE<br><i>4-12-1965</i>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><i>Lorraine Mausoleum</i> |  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Woodlawn Md.</i> |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 12 1965</i>   |                      |  | 25B. NAME OF REGISTRAR<br><i>Robert E. ...</i>  |   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><i>G. Howard Strong 3207 W. North Ave</i>                                     |  |  |  |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

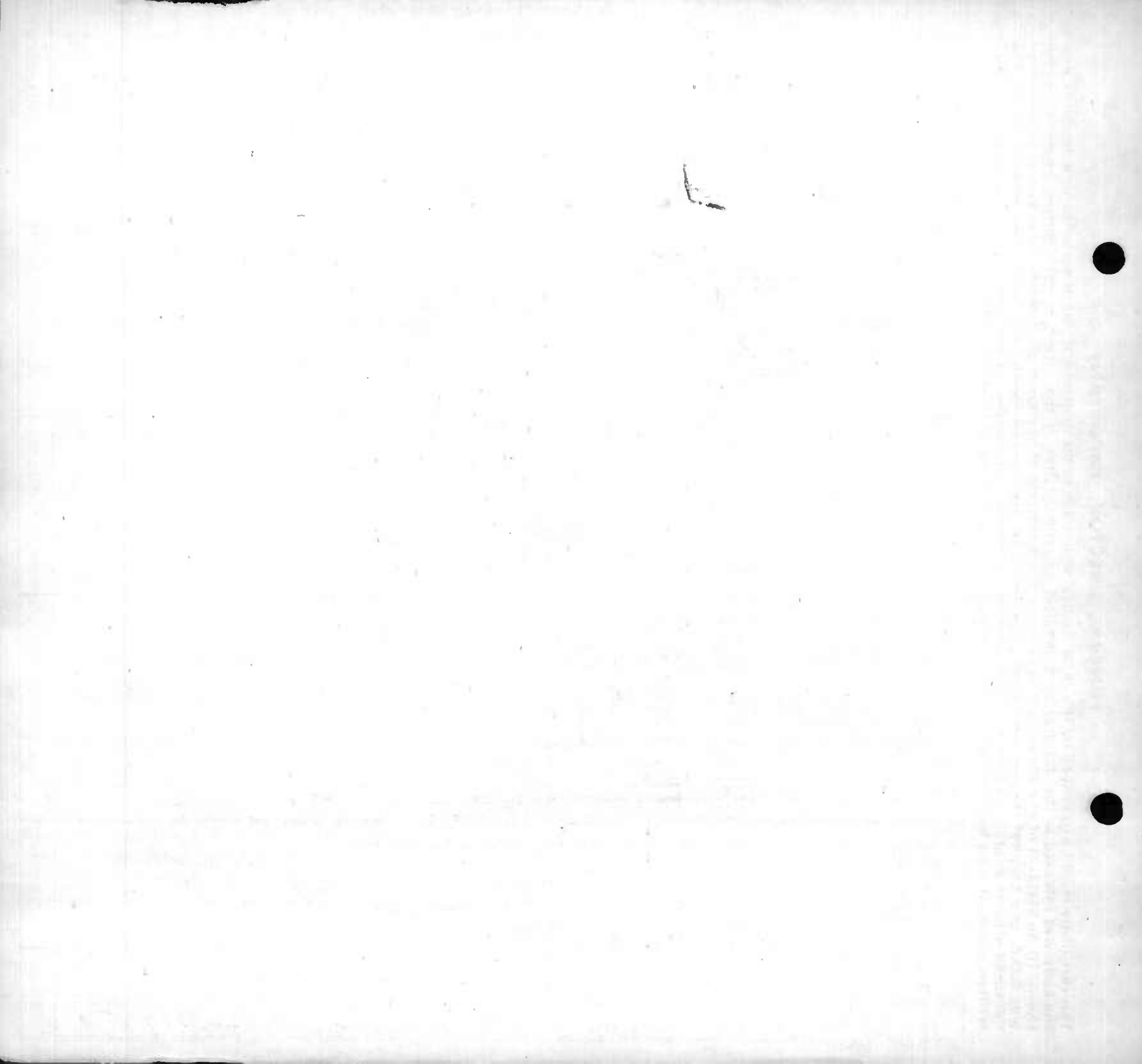
| BALTIMORE CITY HEALTH DEPARTMENT   |                     |  |                                      | Registered No. 65 3856   |   |
|--|---------------------|--|--------------------------------------|--|---|
| BIRTH NO. 65 3856  |                     | CERTIFICATE OF DEATH   |                                      |  |   |
| M.E. CASE NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPHINE S. RADOMSKI</b>  |                                      | 2. DATE AND HOUR OF DEATH<br><b>April 9, 1965</b>  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>1-04</b> |                                      | M.   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>2219 Gough St.<br/>Baltimore 31, Md.</b>  |                     | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>  |                                      | D. STREET ADDRESS (If rural, give location)<br><b>2219 Gough St.</b>                         |   |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widow</b>   | 8. DATE OF BIRTH<br><b>9/15/1889</b> | 9. AGE (In years last birthday)<br><b>75</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY  |                                      | 11. BIRTHPLACE (State or foreign country)<br><b>Poland</b>                                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Poland</b>             |
| 13. FATHER'S NAME<br><b>Joseph Szulczak</b>  |                     | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |                                      |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     | 16. SOCIAL SECURITY NO.<br><b>219-07-3299</b>  |                                      | 17. INFORMANT ADDRESS<br><b>Mary Bawroski 2219 Gough St.</b>                                 |   |
| 18. <b>133.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Secondary Anemia</b>   |                     | CAUSE OF DEATH<br>(A) DUE TO<br><b>Carcinoma of Cecum</b>  |                                      | INTERVAL BETWEEN ONSET AND DEATH<br><b>4/5/65</b><br><b>7/24/64 (?)</b>                      |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     | (B) DUE TO   |                                      | (C)  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |  |                                      |  |   |
| 19A. DATE OF OPERATION<br><b>None</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                      | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                     |  |                                      |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                             |                                      | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>July 24</b> 19 <b>64</b> to <b>April 9</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>April 5</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                     |  |                                      |  |   |
| 23A. SIGNATURE<br><i>Joseph F. Drenga</i><br><b>Joseph F. Drenga, M.D.</b>   |                     |  |                                      | 23B. DATE SIGNED<br><b>April 9, 1965</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)   |                     | 23D. ADDRESS<br><b>209 S. Chester Str.; Baltimore 31, Md.</b>  |                                      |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>4/12/65</b>  |                                      | 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Rosary Cemetery</b>                            |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Co. Md.</b>  |                     |  |                                      |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>  |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Fickel</i>  |                                      | 25C. FUNERAL DIRECTOR ADDRESS<br><b>John M. Weber &amp; Sons Inc.<br/>401 S. Chester St.</b> |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3857   |         |  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                            | Registered No. 65 3857   |  |
|---|---------|--|------------------|---|----------------------------|--|--|
| M.E. CASE NO.   |         |  |                  | 1. NAME OF DECEASED   |                            | 2. DATE AND HOUR OF DEATH  |  |
| (Type or Print) BUHRMAN, Elsie E.   |         |  |                  |   |                            | 4/8/65 9:08 p. M.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                            |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |         | (If not in hospital or institution, give street address or location)                     |                  | A. STATE  |                            | B. COUNTY  |  |
| St. Agnes Hospital  |         |  |                  | Maryland  |                            | AA   |  |
|   |         |  |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |                            |  |  |
|   |         |  |                  | Pasadena  |                            | 52-00  |  |
|   |         |  |                  | D. STREET ADDRESS (If rural, give location)   |                            |  |  |
|   |         |  |                  | 10 Granada Road - Pasadena, Md.   |                            |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)   | If Under 1 Yr. Months Days |  |  |
| Female  | W       | Married  | 11-24-1911       | 53  |                            |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |                            | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Housewife   |         |  |                  | MD  |                            | U.S.   |  |
| 13. FATHER'S NAME   |         |  |                  | 14. MOTHER'S MAIDEN NAME  |                            |  |  |
| Robt. Holmes  |         |  |                  | Eliz. Young   |                            |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         |  |                  | 16. SOCIAL SECURITY NO.   |                            | 17. INFORMANT ADDRESS  |  |
| no  |         |  |                  |   |                            | St. Agnes Hospital Records Balto. 29, Md                             |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |  |                  | CAUSE OF DEATH  |                            | INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  |                  | (A) DUE TO  |                            | Hrs.   |  |
| ANTECEDENT CAUSES   |         |  |                  | (B) DUE TO  |                            |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  |                  | (C) DUE TO  |                            |  |  |
| II  |         |  |                  |   |                            |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |                  |   |                            |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 0   |         |  |                  | no  |                            |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                            |  |  |
|   |         |  |                  |   |                            |  |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?  |                            |  |  |
|   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |   |                            |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 8:45pm 4-8-1965 to 4-8-1965, that (I) (we) lost saw the deceased alive on 4-8-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |   |                            |  |  |
| 23A. SIGNATURE  |         |  |                  | 23B. DATE SIGNED  |                            |  |  |
| Richard Kelly   |         |  |                  | 4/8/65  |                            |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |                  | 23D. ADDRESS  |                            |  |  |
| Richard Kelly, Md   |         |  |                  |   |                            |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY  |                            | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial  |         | 4-13-65  |                  | Loudon PK. Cam.   |                            | Baltimore 29 MD.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR   |                            | ADDRESS  |  |
| APR 12 1965   |         | R. E. Farley, Md   |                  | McCully Funeral Home 237 Pat. Ave   |                            |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                  |  |   | Registered No. 65 3858   |  |
|--|------------------|--|---|--|--|
| BIRTH NO. 65 3858  |                  | CERTIFICATE OF DEATH   |   |  |  |
| M.E. CASE NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) RYKIEL, JOZEFA  |   | 2. DATE AND HOUR OF DEATH<br>4-7-65 12:05 P.M.                                       |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><br>ST AGNES HOSPITAL   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MD. B. COUNTY 1-05<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE<br>D. STREET ADDRESS (If rural, give location)<br>231 S. CHESTER STREET |   |  |  |
| 5. SEX<br>FEMALE   | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>WIDOWED  | 8. DATE OF BIRTH<br>4-22-82                         | 9. AGE (In years lost birthday)<br>82  | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)<br>POLAND |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA      |
| 13. FATHER'S NAME<br>PAUL ROGALSKI   |                  | 14. MOTHER'S MAIDEN NAME<br>AUGUSTINE (STEPMOTHER) WLODKOWSKA  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.<br>220-05-8070   |   | 17. INFORMANT ADDRESS<br>CATON AVES. 21229<br>ST AGNES HOSPITAL RECORDS, WILKINS AND |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) DUE TO AC. MYOCARDIAL INFARCT<br>(B) DUE TO AC. PULMONARY EDEMA<br>(C)   |   | INTERVAL BETWEEN ONSET AND DEATH<br>4 days   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |   |  |  |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br>NO  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4-5-19 65 to 4-7-65 19, that (I) (we) last saw the deceased alive on 4-7-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                    |                  |  |   |  |  |
| 23A. SIGNATURE<br>Manuel J. Rodriguez  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |   | 23B. DATE SIGNED<br>4-7-65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>MANUEL J. RODRIGUEZ  |                  | 23D. ADDRESS<br>St Agnes Hosp  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>4/12/65   |   | 24C. NAME of CEMETERY or CREMATORY<br>Holy Rosary                                    |  |
| 24D. LOCATION<br>Baltimore, Maryland   |                  | 24E. COUNTY (Specify)<br>Baltimore   |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor   |   | 25C. FUNERAL DIRECTOR ADDRESS<br>M. F. SADOWSKI & SONS, 1808 EASTERN AVE             |  |

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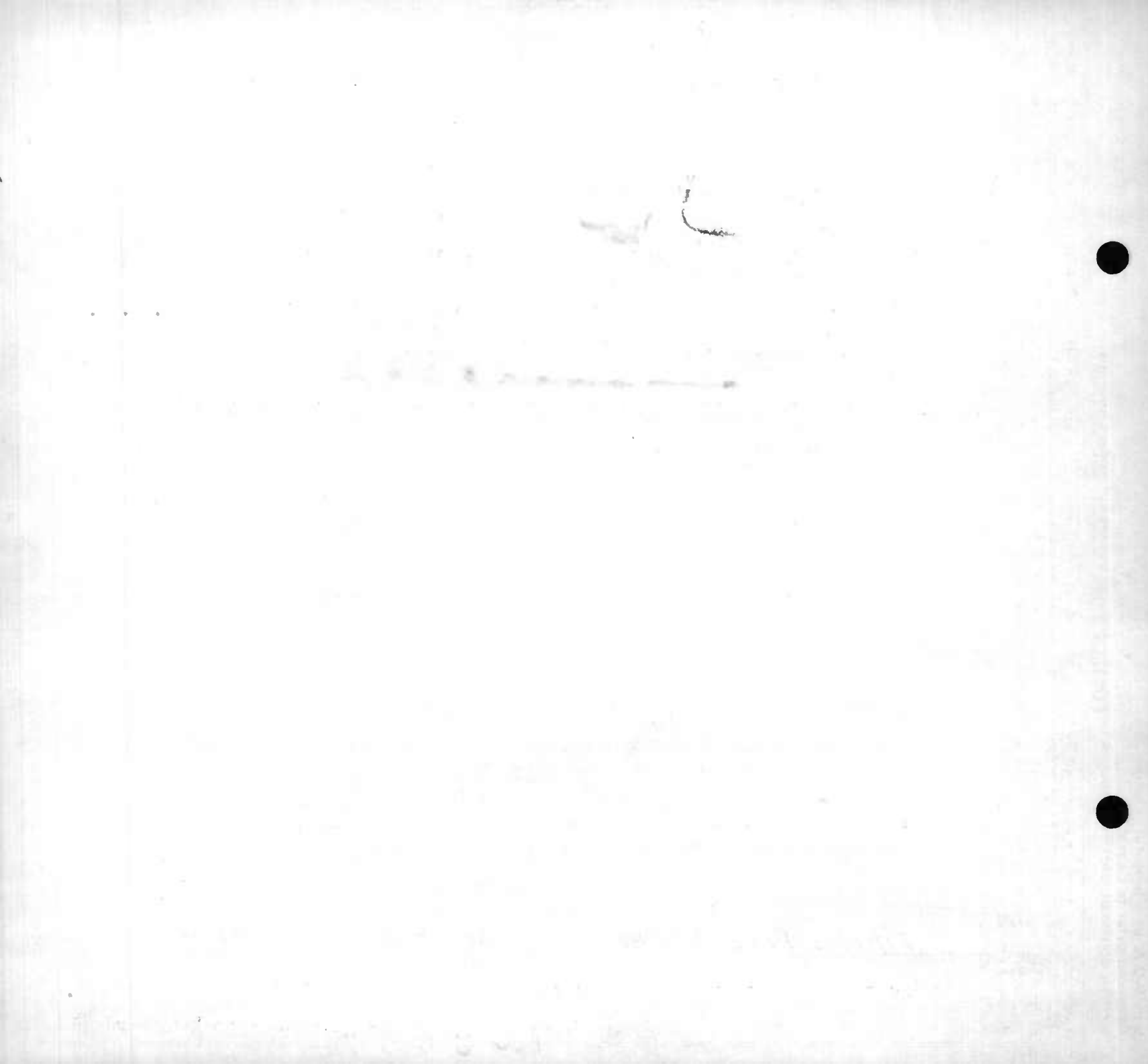
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3859  |                         |  |   | BALTIMORE CITY HEALTH DEPARTMENT  |   | CERTIFICATE OF DEATH  |   | Registered No. 65 3859            |  |
|--|-------------------------|--|---|---|---|---|---|-----------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Nicholas Dzwonczyk</b>   |                         |  |   | 2. DATE AND HOUR OF DEATH<br><b>April 10 1965</b>   <b>7:15 P.M.</b>  |   |   |   |                                   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>South Baltimore General Hospital</b>   |                         |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>26-02</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>4778 Chatford Avenue # 6</b> |   |   |   |                                   |  |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, <del>NEVER</del> MARRIED<br>WIDOWED, <del>UN</del> FORCED (specify)<br><b>Married</b>      | 8. DATE OF BIRTH<br><b>Nov 11 1919</b>              | 9. AGE (In years last birthday)<br><b>45</b>  | II Under 1 Yr. Months Days  |   | II Under 24 Hrs. Hours Min.                     |                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Watchmaker</b>   |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Jeweler</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Logan West Virginia</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b> |                                   |  |
| 13. FATHER'S NAME<br><b>Theodore Dzwonczyk</b>   |                         |  |   | 14. MOTHER'S MAIDEN NAME<br><b>Milina Dzwonczyk</b>   |   |   |   |                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or date of service<br><b>Yes World War 11</b>   |                         |  |   | 16. SOCIAL SECURITY NO.<br><b>232 22 7048</b>   |   | 17. INFORMANT<br><b>Alice Dzwonczyk</b> ADDRESS <b>4778 Chatford Avenue</b> |   |                                   |  |
| 18. I <b>1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma, poorly differentiated</b><br><b>Probably of the lung</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                         |  |   | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 1/2 mos.</b>                       |   |                                   |  |
| 19A. DATE OF OPERATION<br><b>4/10/65</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |   |                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |   |                                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |   |   |                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/1/65</b> to <b>4/10/65</b> that (I) (we) last saw the deceased alive on <b>4/10/65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |  |   |   |   |   |   |                                   |  |
| 23A. SIGNATURE<br><b>Thomas Paul Bigbee</b> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                         |  |   | 23B. DATE SIGNED<br><b>4-11-65</b>  |   |   |   |                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>THOMAS PAUL BIGBEE</b> M.D.   |                         |  |   | 23D. ADDRESS<br><b>SOUTH BALTIMORE GENERAL HOSPITAL</b>   |   |   |   |                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>Apr 14 1965</b>  |   | 24C. NAME of CEMETERY or CREMATORY<br><b>Holy Trinity Cemetery</b>  |   | 24D. LOCATION<br><b>Elkridge</b>  |   | 24D. LOCATION<br><b>Maryland.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |   | 25C. FUNERAL DIRECTOR<br><b>The Rippel Brothers</b> ADDRESS <b>1800 E Lombard St</b>  |   |   |   |                                   |  |

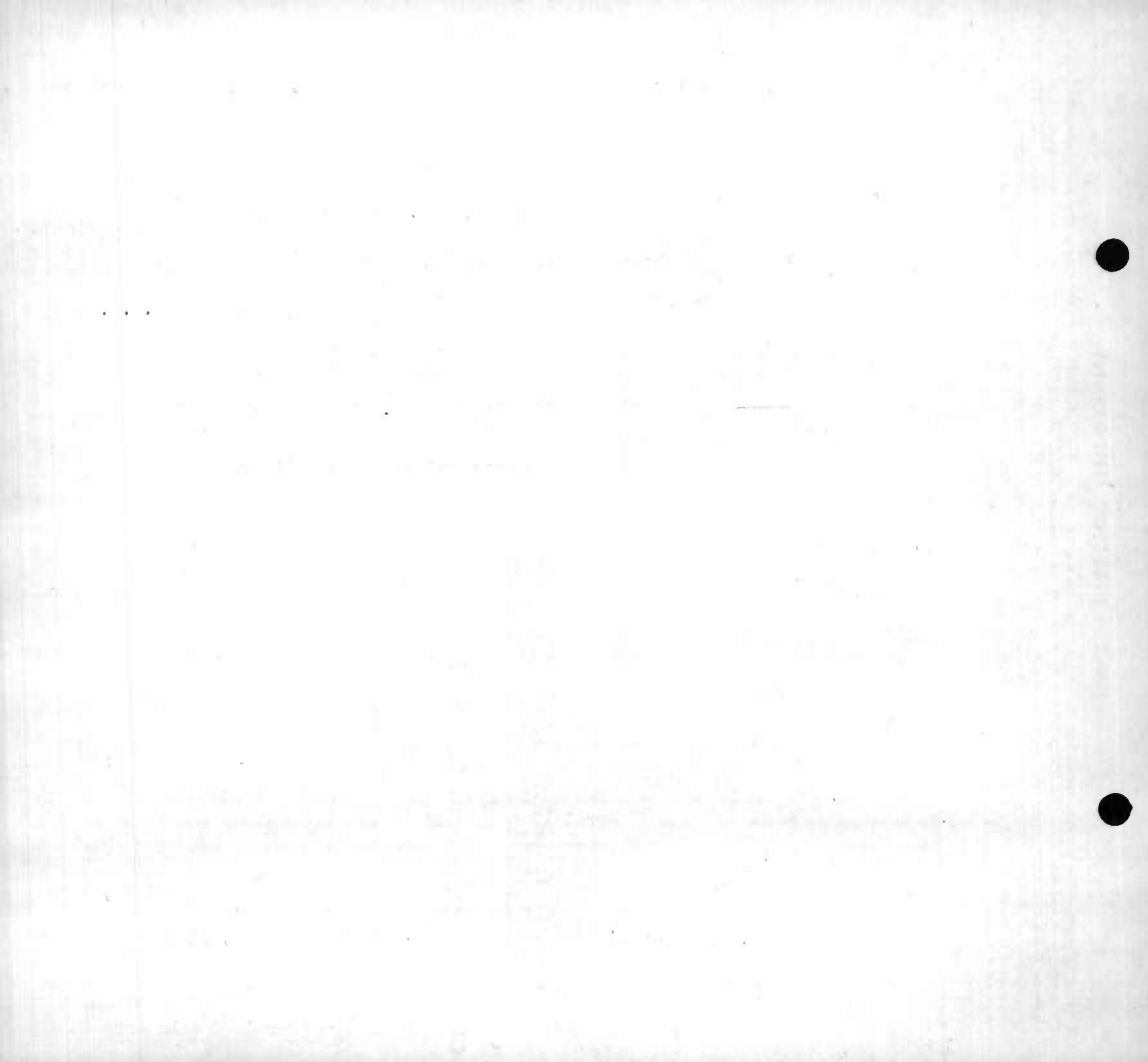




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3860  |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | CERTIFICATE OF DEATH  |  | Registered No. 65 3860   |  |
|--|--|--|--|--|--|---|--|--|--|
| M.E. CASE NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH   |  |  |  |
|  |  |  |  | DiPete, Peter Joseph   |  | April 10, 1965  |  | 12:00 noon M.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  | A. STATE  |  | B. COUNTY  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |  |  |  | Maryland   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) |  | 1-05   |  |
| St. Joseph Hospital  |  |  |  | Baltimore 21231  |  | D. STREET ADDRESS (If rural, give location)                             |  |  |  |
| 115 S. Chester Street  |  |  |  | B. DATE OF BIRTH   |  | 9. AGE (In years last birthday)   |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                   |  |
| 5. SEX Male  |  |  |  | 6. RACE White  |  |   |  | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widower            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |   |  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Insurance Retired  |  |  |  | Life Insurance   |  |   |  | Italy  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |  |  | U.S.A.   |  |   |  |  |  |
| 13. FATHER'S NAME  |  |  |  | 14. MOTHER'S MAIDEN NAME   |  |   |  |  |  |
| Sadina DiPete  |  |  |  | Felicie Unk  |  |   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  | 16. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT  |  |
| No   |  |  |  | 212 01 8119  |  |   |  | Benjamin J. DiPete 5013 Remmell Avenue                                   |  |
| 18. 183701   |  |  |  | CAUSE OF DEATH   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |  |  | (A) Primary carcinoma of the liver   |  |   |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  |  |  | DUE TO   |  |   |  |  |  |
| ANTECEDENT CAUSES  |  |  |  | (B) DUE TO   |  |   |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  | (C)  |  |   |  |  |  |
| II   |  |  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                       |  |   |  |  |  |
| 19A. DATE OF OPERATION   |  |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20A. AUTOPSY? (Yes or No)  |  |
|  |  |  |  |  |  |   |  | Yes  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |  |  |  |  |  |   |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  |  |  | 21E. INJURY OCCURRED   |  |   |  | 21F. HOW DID INJURY OCCUR?   |  |
|  |  |  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 4 1965 to April 10 1965, that (I) (we) last saw the deceased alive on April 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |  |
| 23A. SIGNATURE   |  |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |   |  | 23B. DATE SIGNED   |  |
| William B. VandeGrift  |  |  |  |  |  |   |  | April 10, 1965   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |  |  | 23D. ADDRESS   |  |   |  |  |  |
| William B. VandeGrift  |  |  |  | 1400 N. Caroline Street, 21213   |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |  |  | 24B. DATE  |  |   |  | 24C. NAME of CEMETERY or CREMATORY                                       |  |
| Burial   |  |  |  | Apr 13 1965  |  |   |  | New Cathedral Cemetery   |  |
| 24D. LOCATION (City, town, or county) (State)  |  |  |  | 24E. DATE REC'D BY HEALTH DEPT.  |  |   |  | 24F. NAME OF REGISTRAR   |  |
| Old Frederick Road Md  |  |  |  | APR 12 1965  |  |   |  | The Poppel Brothers 1800 E Lombard St                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  |  |  | 25B. NAME OF REGISTRAR   |  |   |  | 25C. FUNERAL DIRECTOR  |  |
|  |  |  |  |  |  |   |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   |  |  |  |   |                                    |                                   |  |
|---|-------------------------|---|---|--|--|--|---|------------------------------------|-----------------------------------|--|
| BIRTH NO. 65 3861   |                         |   |   |  | CERTIFICATE OF DEATH   |  |   |                                    |                                   |  |
| M.E. CASE NO.   |                         |   |   |  | Registered No. 65 3861   |  |   |                                    |                                   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPH WINSTON</b>  |                         |   |   |  | 2. DATE AND HOUR OF DEATH<br><b>1:30 AM 4/10/65</b> M.   |  |   |                                    |                                   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>USPHS HOSPITAL</b>  |                         |   |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>22-01</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE</b><br>D. STREET ADDRESS (If rural, give location) <b>19 W. MONTGOMERY ST</b> |  |   |                                    |                                   |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>NEGRO</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>                                | 8. DATE OF BIRTH<br><b>8/4/09</b>                           | 9. AGE (In years lost birthday)<br><b>55</b>                             | If Under 1 Yr. Months: Days: Hours: Min.   |  | If Under 24 Hrs. Min.                       |                                    |                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>OILER-SHIP</b>  |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>MERCHANT SEAMAN</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>WEST VA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |                                    |                                   |  |
| 13. FATHER'S NAME<br><b>NICHOLAS WINSTON</b>  |                         |   |   |  | 14. MOTHER'S MAIDEN NAME<br><b>LUCY BROWN</b>  |  |   |                                    |                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES</b>  |                         |   | 16. SOCIAL SECURITY NO.<br><b>218 055010</b>                |  | 17. INFORMANT<br><b>ALENE WINSTON 194 MONTGOMERY ST</b>  |  |   |                                    |                                   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CARCINOMA, LUNG</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                         |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 YRS.</b>  |  |   |                                    |                                   |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>                                  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |                                    |                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |   |                                    |                                   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |   |                                    |                                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/1/65</b> 19 <b>65</b> to <b>4/10</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |   |  |  |  |   |                                    |                                   |  |
| 23A. SIGNATURE<br><b>James E. Taylor Jr.</b>  |                         |   |   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  |   | 23B. DATE SIGNED<br><b>4/10/65</b> |                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JAMES E. TAYLOR, JR.</b>   |                         |   |   |  | 23D. ADDRESS<br><b>USPHS HOSPITAL BALTO, MD</b>  |  |   |                                    |                                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burned</b>   |                         | 24B. DATE<br><b>4/14/65</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>U.S. NATIONAL</b>               |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE</b>    |   |                                    |                                   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>   |                         |   | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>           |  |  | 25C. FUNERAL DIRECTOR<br><b>Wm. B. P. Harris</b>                     |   |                                    | ADDRESS<br><b>638 N. Green St</b> |  |

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BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 3862

|   |  |   |  |
|---|--|---|--|
| BIRTH NO. 65 3862   |  | 2. DATE AND HOUR OF DEATH 4-10-65 3:20 A.M.   |  |
| M.E. CASE NO.   |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |
| 1. NAME OF DECEASED (Type or Print) Governor Nelson   |  | 4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland #21224  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore  |  |
| D. STREET ADDRESS (If rural, give location)<br>661 West Saratoga Street #21201  |  | 5. SEX Male 6. RACE Negro 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Married  |  |
| 8. DATE OF BIRTH 7-7-07   |  | 9. AGE (In years last birthday) 57  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER STEEL   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  |
| 11. BIRTHPLACE (State or foreign country) North Carolina  |  | 12. CITIZEN OF WHAT COUNTRY? U. S. A.   |  |
| 13. FATHER'S NAME GEORGE NELSON   |  | 14. MOTHER'S MAIDEN NAME NANCY JONES  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |  | 16. SOCIAL SECURITY NO. 237-40-1213   |  |
| 17. INFORMANT RECORDS: B.C.H. 4940 Eastern Avenue #21224  |  | ADDRESS   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Metastatic Carcinoma of Pancreas   |  | INTERVAL BETWEEN ONSET AND DEATH 3 Months   |  |
| ANTECEDENT CAUSES (DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.)   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  |
| 19A. DATE OF OPERATION 0  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No) No  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4-2-19 65 to 4-10-19 65, that (I) (we) lost saw the deceased alive on 4-10-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE Dr. Charles Carpenter  |  | 23B. DATE SIGNED 4-10-65  |  |
| 23C. PHYSICIAN'S NAME (Type) Dr. Charles Carpenter  |  | 23D. ADDRESS 4940 Eastern Avenue #21224   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE 4/13/65   |  |
| 24C. NAME OF CEMETERY OR CREMATORY ARBUTHNOT MEM PK.  |  | 24D. LOCATION (City, town, or county) (State) Baltimore Co. MD  |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 12 1965   |  | 25B. NAME OF REGISTRAR  |  |
| 25C. FUNERAL DIRECTOR   |  | ADDRESS   |  |

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

George Wilson  
Landscape

1877-1878

Painted with the same colors as the original

by George Wilson

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |   |  |   | Registered No. <span style="font-size: 1.2em;">65 3863</span>   |  |
|---|---|--|---|---|--|
| BIRTH NO. <span style="font-size: 1.2em;">65 3863</span>  |   |  |   |   |  |
| M.E. CASE NO. <span style="font-size: 1.2em;">65 3863</span>  |   |  |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Carsley Cassuis</span>   |   | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">4-11-65</span>                                |   | 2:30 A.M.   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                      |   | A. STATE <span style="font-size: 1.2em;">Maryland</span>  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><span style="font-size: 1.2em;">Provident Hospital</span>  |   | B. COUNTY <span style="font-size: 1.2em;">15-37</span>   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.2em;">Baltimore</span> |  |
|   |   | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.2em;">2520 North Ellamont</span>  |   |   |  |
| 5. SEX<br><span style="font-size: 1.2em;">Male</span>   | 6. RACE<br><span style="font-size: 1.2em;">Negro</span> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.2em;">Married</span> | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">Jan 7-1899</span> | 9. AGE (In years lost birthday)<br><span style="font-size: 1.2em;">66</span>  | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Self Employed STAIRS KEEPER</span>   |   | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Pocomoke MD</span>                             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">U.S.A.</span>   |   | 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Samuel Carsley</span>                                 |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Lucretia</span>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">NO</span>   |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">219-18-1559A</span>                             |   | 17. INFORMANT ADDRESS<br><span style="font-size: 1.2em;">Mary Carsley 2520 North Ellamont St</span>                         |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.2em;">Intestinal Obstruction</span>   |   | CAUSE OF DEATH<br>(A) DUE TO<br><span style="font-size: 1.2em;">Obdominal Carcinomatosis</span>            |   | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   | (B) DUE TO   |   |   |  |
| (C) _____   |   |  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |   | <span style="font-size: 1.2em;">Congestive Heart Failure</span>  |   |   |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">0</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>     |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">3-24</span> 19 <span style="font-size: 1.2em;">65</span> to <span style="font-size: 1.2em;">4-11</span> 19 <span style="font-size: 1.2em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4-11</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |   |   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Ruperto M. Manankil</span>  |   | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">4-11-65</span>   |   | 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">Ruperto M. Manankil</span>                                  |  |
| 23D. ADDRESS<br><span style="font-size: 1.2em;">Provident Hospital</span>   |   | 23E. ADDRESS<br><span style="font-size: 1.2em;">1514 Division St. Baltimore, Maryland</span>               |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>   |   | 24B. DATE<br><span style="font-size: 1.2em;">4/14/65</span>  |   | 24C. NAME of CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Hopkins Chapel</span>                                 |  |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">St. Ignace, Howard Co. MD</span>   |   | 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">APR 12 1965</span>                      |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">R. E. Galt</span>   |  |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">M. M. Galt</span>  |   | 25D. ADDRESS<br><span style="font-size: 1.2em;">638 N. Galt St.</span>                                     |   |   |  |

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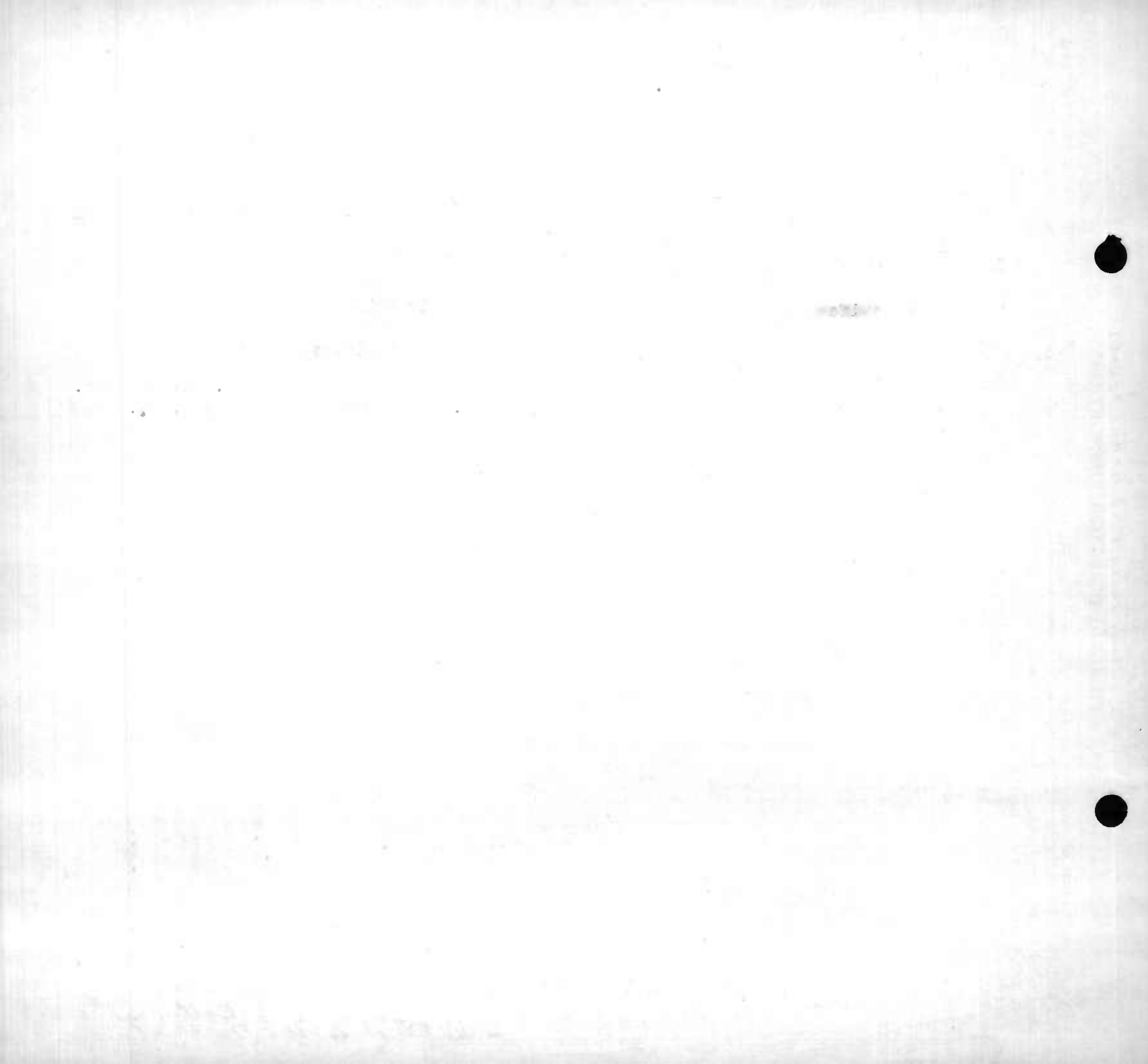
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Released Unconditionally by  
Or Lutheran M & O Exan. Office  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

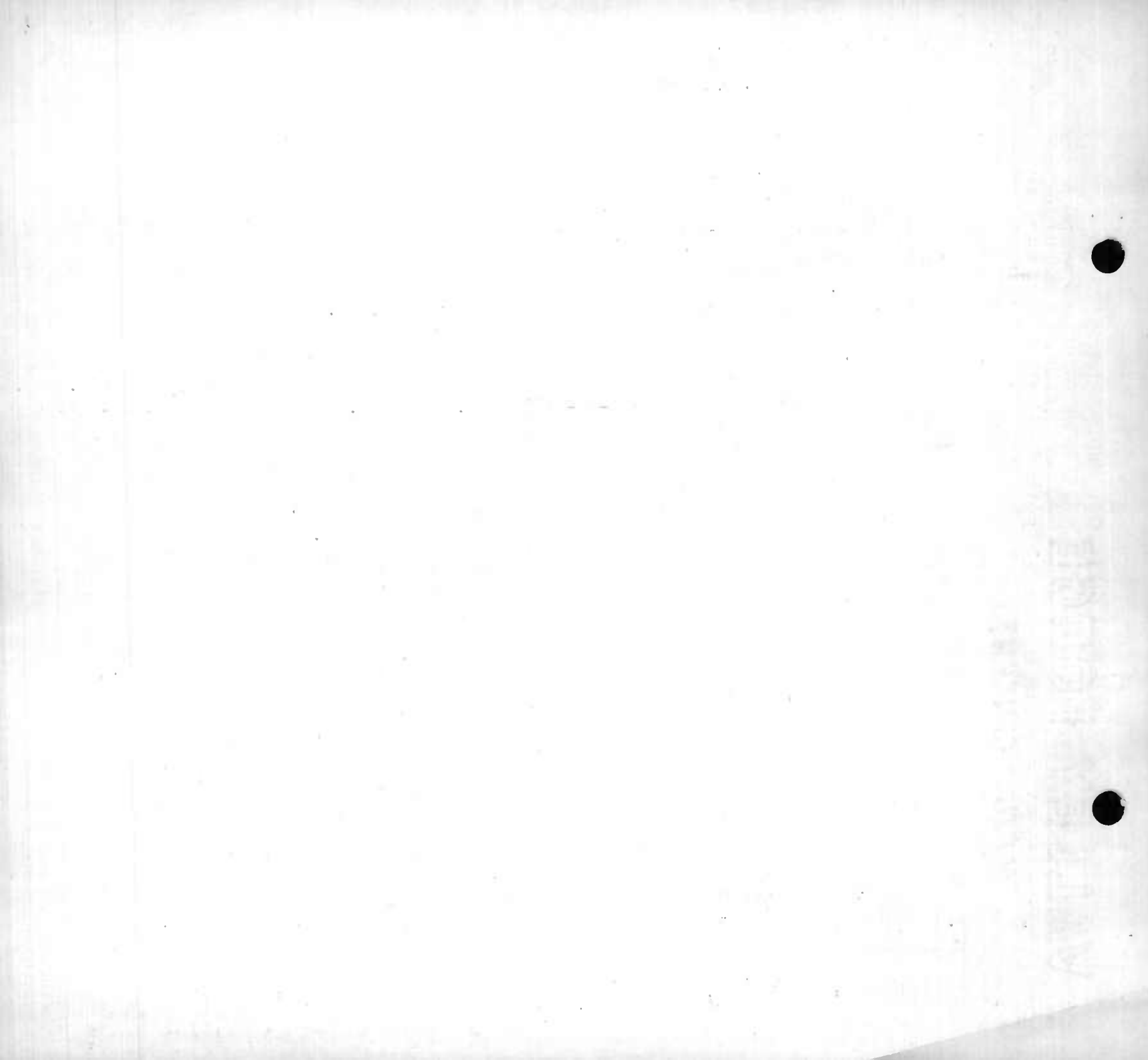
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|---|--|------------------------|--|--|--|--|--|--|--|---|--|
| BIRTH NO. 65 3864   |  |                        |  | BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | Registered No. 65 3864   |  |   |  |
| M.E. CASE NO.   |  |                        |  | CERTIFICATE OF DEATH   |  |  |  |  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) ROUNDS, Judith A.  |  |                        |  | 2. DATE AND HOUR OF DEATH<br>4/10/65 12:40 A.M.  |  |  |  |  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |                        |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY 7-01            |  |  |  |  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Johns Hopkins Hospital  |  |                        |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE   |  |  |  |  |  |   |  |
|   |  |                        |  | D. STREET ADDRESS (If rural, give location)<br>622 N. Ellwood Ave 21205  |  |  |  |  |  |   |  |
| 5. SEX<br>FEMALE  |  | 6. RACE<br>White       |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Widow  |  | 8. DATE OF BIRTH<br>3/4/83   |  | 9. AGE (In years last birthday)<br>82  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife  |  |                        |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  |  |  | 11. BIRTHPLACE (State or foreign country)<br>Virginia  |  | 12. CITIZEN OF WHAT COUNTRY?                              |  |
| 13. FATHER'S NAME<br>Mallory West   |  |                        |  | 14. MOTHER'S MAIDEN NAME<br>Mary Elizabeth Benton  |  |  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No None   |  |                        |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br>Mrs. Betty Edwards                                      |  | ADDRESS<br>622 N. Ellwood Ave. Baltimore, Md. 21205  |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) MYOCARDIAL INFARCTION<br>(B) DIABETES MELLITUS<br>(C) _____<br>INTERVAL BETWEEN ONSET AND DEATH<br>1 Hour<br>Many years |  |                        |  |  |  |  |  |  |  |   |  |
| 19. DATE OF OPERATION   |  |                        |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br>No  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                           |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  |                        |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |                        |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |                        |  |  |  |  |  |  |  |   |  |
| 23A. SIGNATURE<br>John V. Segre MD  |  |                        |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |  |  | 23B. DATE SIGNED<br>4/10/65  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Gino V. Segre   |  |                        |  | M.D. Johns Hopkins Hospital  |  |  |  | 23D. ADDRESS   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>4/13/1965 |  | 24C. NAME OF CEMETERY or CREMATORY<br>Baltimore National Cemetery  |  |  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                           |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |  |                        |  | 25B. NAME OF REGISTRAR<br>R. E. Stokely  |  |  |  | 25C. FUNERAL DIRECTOR<br>Wm. J. Edwards & Sons<br>Baltimore, Md. 21217<br>North & Cal. Avenues |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

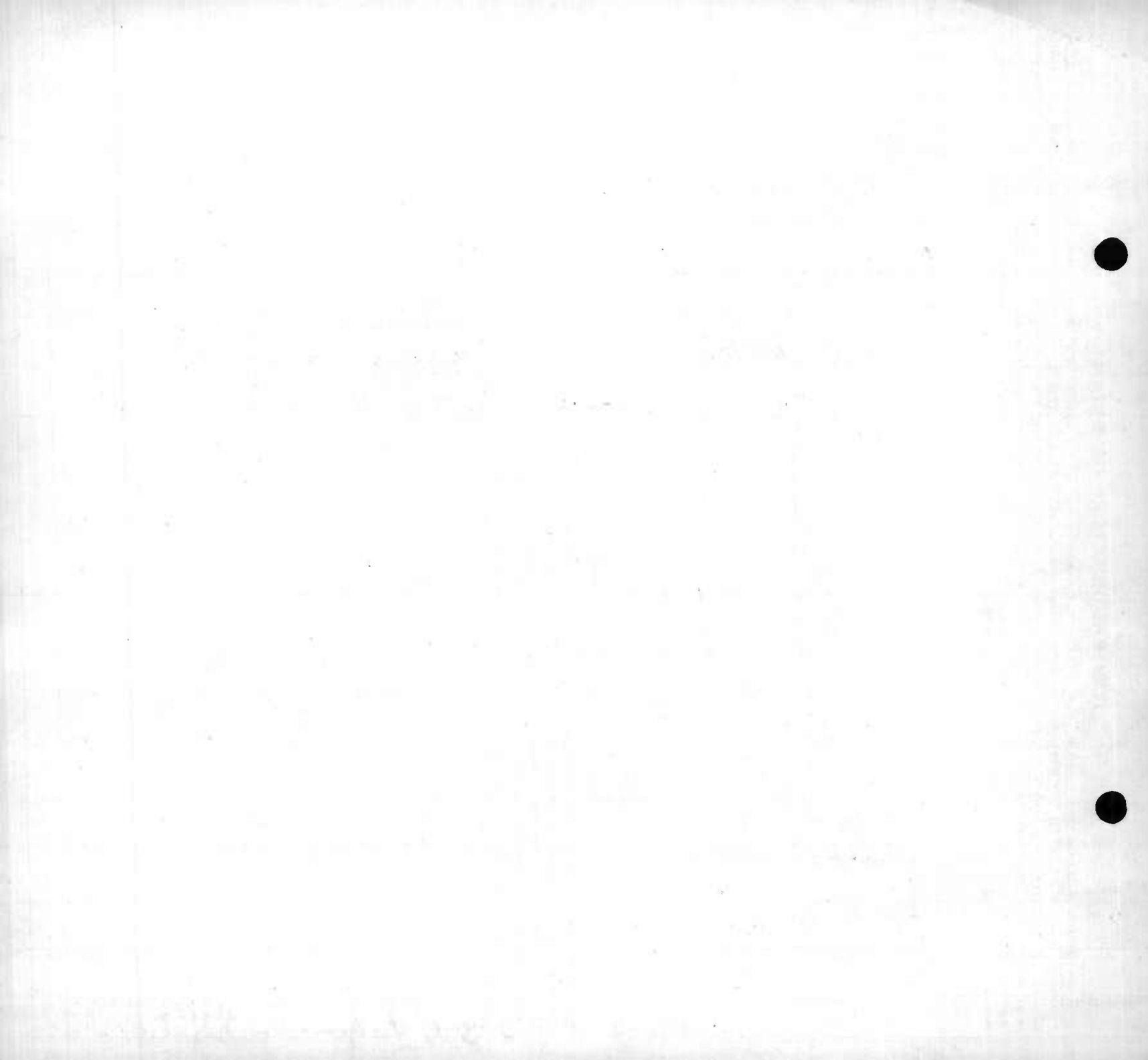
| BALTIMORE CITY HEALTH DEPARTMENT  |                      |  |   | Registered No. 65 3865   |  |
|---|----------------------|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <div> <p>BIRTH NO. 65 3865</p> <p>M.E. CASE NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>James H. Sharrer</b></p> </div> <div> <p>2. DATE AND HOUR OF DEATH <b>April 8, 1965</b> <b>8 40 P</b> M.</p> </div> </div>   |                      |  |   |  |  |
| <p>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5203 Wilton Heights Avenue Baltimore, Maryland 21215</b></p>  |                      |  | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>27-18</b></p> <p>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Baltimore</b></p> <p>D. STREET ADDRESS (If rural, give location) <b>5203 Wilton Heights Avenue 21215</b></p> |  |  |
| 5. SEX <b>Male</b>  | 6. RACE <b>White</b> | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify) <b>Married</b>                                   | 8. DATE OF BIRTH <b>3/7/1908</b>  | 9. AGE (In years last birthday) <b>57</b>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Chauffer</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY <b>Enterprise Fuel</b>   |   | 11. BIRTHPLACE (State or foreign country) <b>Fort Hunt, Va.</b>  |  |
| 13. FATHER'S NAME <b>Henry L. Sharrer</b>   |                      |  | 14. MOTHER'S MAIDEN NAME <b>Ora</b>   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>   |                      | 16. SOCIAL SECURITY NO. <b>218-10-6172</b>   |   | 17. INFORMANT <b>Mrs. Thelma E. Sharrer</b> ADDRESS <b>5203 Wilton Hgts. Ave. Baltimore, Md. 21215</b> |  |
| <p>18. <b>420.1 I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |                      |  | <p>CAUSE OF DEATH</p> <p>(A) <b>ascendium, myo -</b></p> <p>DUE TO</p> <p>(B) <b>cardial infarction</b></p> <p>DUE TO</p> <p>(C) <b>Emphysema, Pericarditis</b></p>   |  |  |
| <p>INTERVAL BETWEEN ONSET AND DEATH</p>   |                      |  |   |  |  |
| <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</p>   |                      |  |   |  |  |
| 19A. DATE OF OPERATION <b>0</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>3/3/65</b> 19 to <b>3/3/65</b> 19 that (I) (we) last saw the deceased alive on <b>3/3/65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>  |                      |  |   |  |  |
| 23A. SIGNATURE <b>Samuel Wilson</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |                      |  |   | 23B. DATE SIGNED <b>4/9/65</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>Samuel Wilson</b> M.D.  |                      |  |   | 23D. ADDRESS   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |                      | 24B. DATE <b>4/12/1965</b>   |   | 24C. NAME of CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>  |  |
| 24D. LOCATION (City, town, or county) <b>Woodlawn, Maryland</b>   |                      | 24E. (State)   |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>APR 12 1965</b>  |                      | 25B. NAME OF REGISTRAR <b>W. E. Taylor</b>   |   | 25C. FUNERAL DIRECTOR <b>W. E. Taylor &amp; Sons</b> ADDRESS <b>Baltimore, Md. 21217 North Ave.</b>    |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

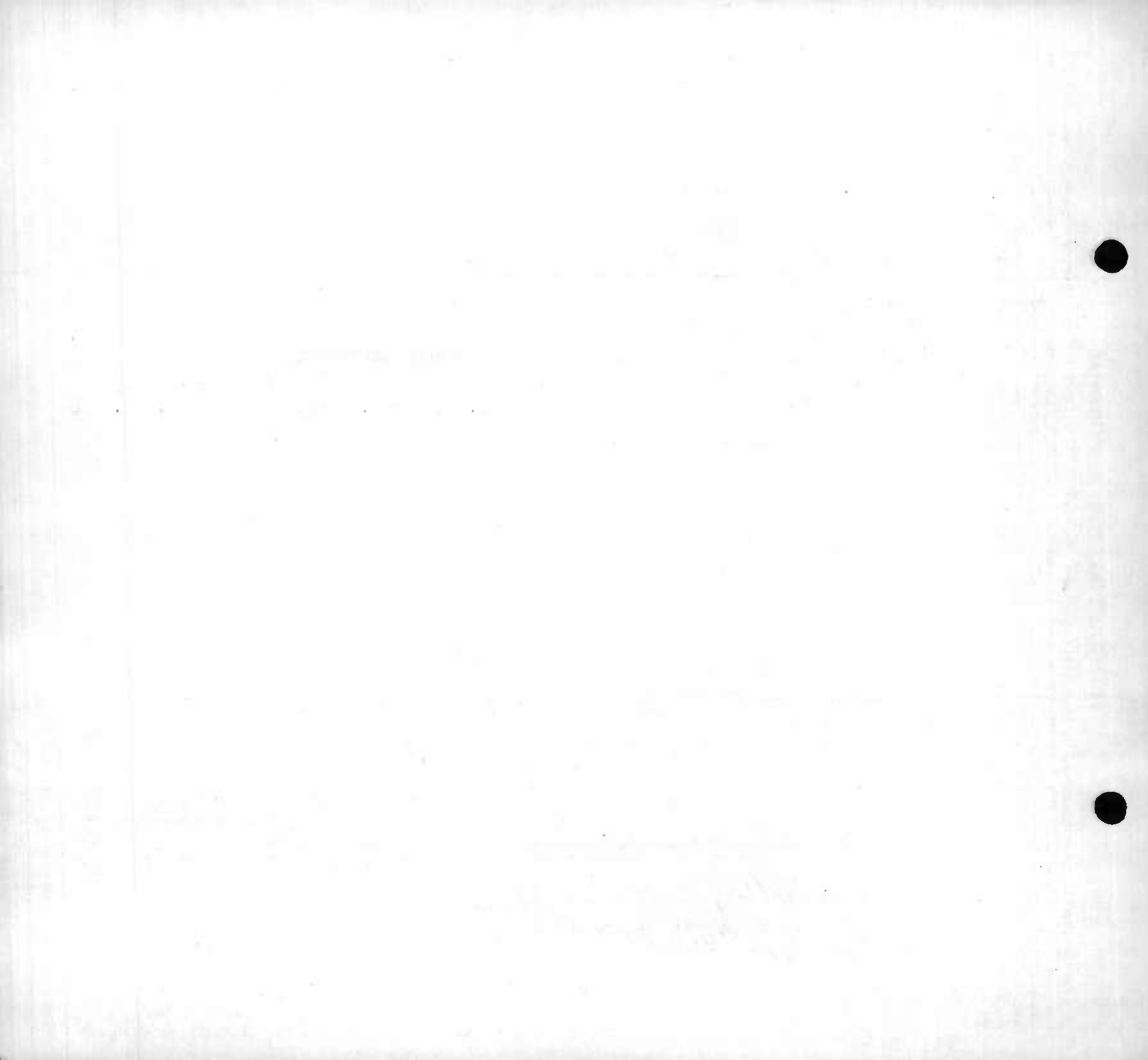
|  |                        |   |  |  |   |
|--|------------------------|---|--|--|---|
| BIRTH NO. 65 3866  |                        | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3866   |   |
| M.E. CASE NO.  |                        |   | CERTIFICATE OF DEATH   |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) Charles E. Miller   |                        |   | 2. DATE AND HOUR OF DEATH<br>4-10-65 12 <sup>55</sup> P.M.   |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Bon Secours Hosp.   |                        |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 25-52<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore<br>D. STREET ADDRESS (If rural, give location) 3207 Stanley Rd (27) |  |   |
| 5. SEX<br>M  | 6. RACE<br>W           | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>M   | 8. DATE OF BIRTH<br>12-25-90   | 9. AGE (In years last birthday)<br>74                                    | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Barber  |                        | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>Md.                         |   |
| 13. FATHER'S NAME<br>Edward Miller   |                        |   | 12. CITIZEN OF WHAT COUNTRY?<br>Am.  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No None  |                        |   | 14. MOTHER'S MAIDEN NAME<br>Cornelia Langford  |  | 17. INFORMANT<br>Hydia Altomare                               |
| 16. SOCIAL SECURITY NO.<br>213-10-1924   |                        |   | ADDRESS<br>Bt Ho. Md.  |  |   |
| 18. I<br>422.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Chronic Emphysema & CHF |                        |   | CAUSE OF DEATH<br>(A) Terminal Pneumonia<br>DUE TO<br>(B) Thrombosis<br>DUE TO<br>(C) Generalized Arteriosclerosis w/ ASCVD<br>years   |  | INTERVAL BETWEEN ONSET AND DEATH<br>2 days<br>1 week<br>years |
| 19A. DATE OF OPERATION<br>2  |                        |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                        | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from March 3 19 65 to April 10 19 65, that (I) (we) lost saw the deceased alive on April 10 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                        |   |  |  |   |
| 23A. SIGNATURE<br>Zenaida C. Palad   |                        |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED<br>April 10, 1965                            |
| 23C. PHYSICIAN'S NAME (Type)<br>ZENAIDA C. PALAD   |                        |   | 23D. ADDRESS<br>Bon Secours Hospital   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   | 24B. DATE<br>4/14/1965 | 24C. NAME of CEMETERY or CREMATORY<br>Meadowridge Cemetery  |  | 24D. LOCATION (City, town, or County) (State)<br>Elkridge, Maryland      |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965   |                        | 25B. NAME OF REGISTRAR<br>R. E. E. E.   |  | 25C. FUNERAL DIRECTOR<br>Wm. J. Dickerson & Sons                         |   |
| ADDRESS<br>Baltimore, Md. 21217  |                        |   |  |  |   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3867   |                         |   |   | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3867  |                              |
|---|-------------------------|---|---|---|--|---|------------------------------|
| M.E. CASE NO.   |                         |   |   | CERTIFICATE OF DEATH  |  |   |                              |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Selma Marcus</b>  |                         |   |   | 2. DATE AND HOUR OF DEATH<br><b>April 9, 1965</b> <span style="float: right;">3 P. M.</span>  |  |   |                              |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Agnes Hospital</b>  |                         |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>28-04</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>4507 Manordene Road 21229</b> |  |   |                              |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                                | 8. DATE OF BIRTH<br><b>4/18/1890</b>                |   | 9. AGE (In years last birthday)<br><b>74</b>   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                      |                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY                   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                     |   | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME<br><b>William Alexander</b>   |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Hannah Hartzberg</b> |   |  |   |                              |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No None</b>  |                         |   | 16. SOCIAL SECURITY NO.                             |   | 17. INFORMANT ADDRESS<br><b>4116 Ronis Road</b><br><b>Mr. Wilbur O. Marcus Pikesville, Md. 8</b> |   |                              |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>420.1 I</b><br><b>Coronary Myocardial Infarction</b><br>A. DUE TO<br><b>Chronic Hypertension and Atherosclerosis</b><br>B. DUE TO<br><b>187.1</b><br>C. _____ |                         |   |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>2 da.</b>  |  |   |                              |
| II. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |   |   |   |  |   |                              |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |   |   |  |   |                              |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |                              |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |                              |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |  |   |                              |
| 22. I certify that (I) (this hospital) attended the deceased from <b>6-11-1948</b> to <b>4-9-1965</b> , that (I) (we) last saw the deceased alive on <b>4-7-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |   |   |  |   |                              |
| 23A. SIGNATURE<br><b>Wilmer K. Gallagher Jr.</b>  |                         |   |   | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  | 23B. DATE SIGNED<br><b>4-10-65</b>  |                              |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Wilmer K. Gallagher Jr.</b>  |                         |   |   | 23D. ADDRESS<br>M.O. <b>6209 Frederick Box Baltimore 28 Md.</b>   |  |   |                              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4/11/1965</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Hebrew Friendship Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |                              |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert S. [Signature]</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Wilbur O. Marcus Pikesville, Md. 21217</b>  |  |   |                              |

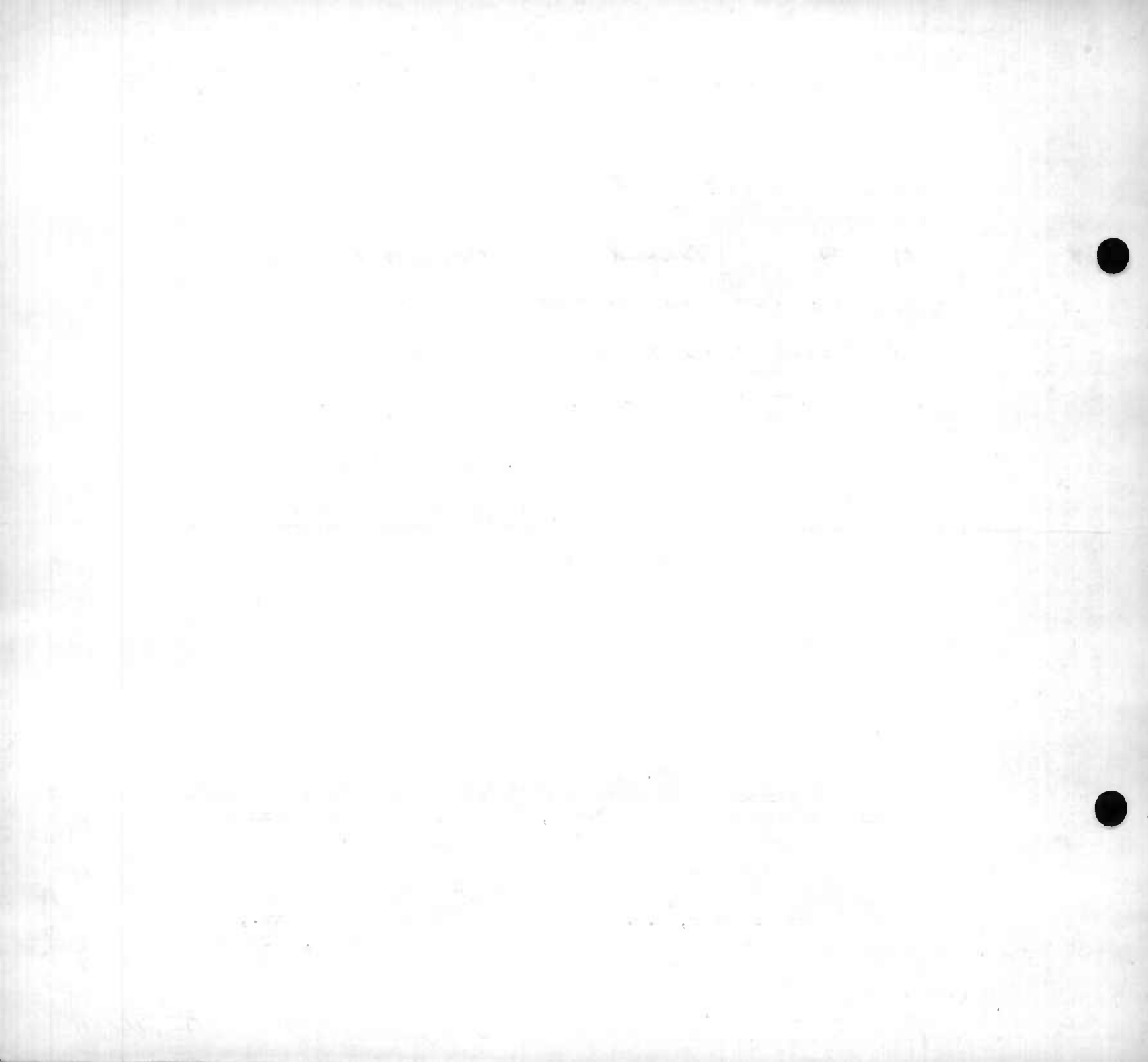




# FUNERAL DIRECTOR: IMPORTANT

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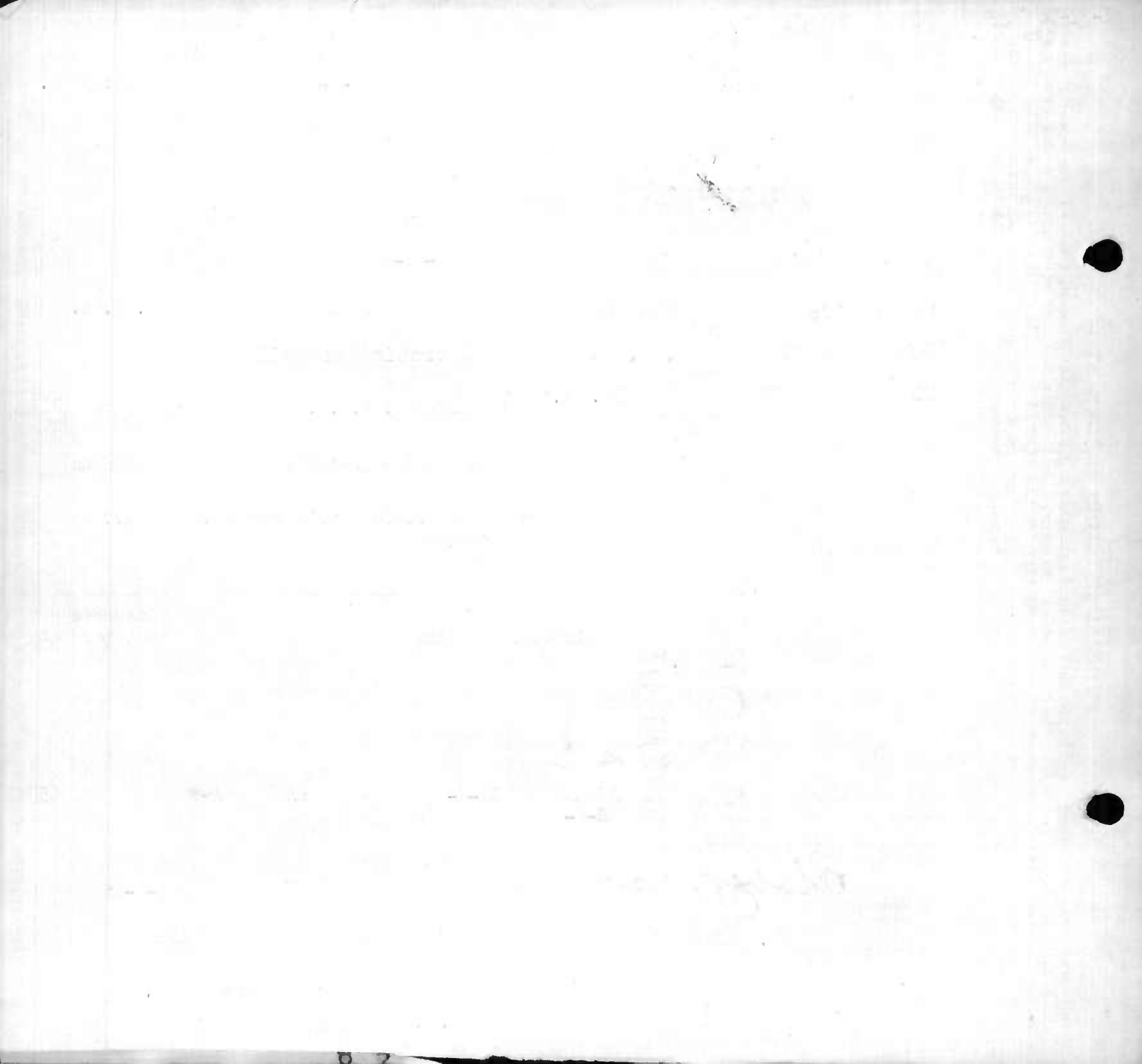
| BIRTH NO. 65 3868   |                     |  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3868   |  |
|---|---------------------|--|--|---|--|--|--|
| M.E. CASE NO.   |                     |  |  | CERTIFICATE OF DEATH  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>ELMER H. RENEHAN</b>  |                     |  |  | 2. DATE AND HOUR OF DEATH<br><b>APRIL 6, 1965 7:45 P. M.</b>  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                     |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |                     | (If not in hospital or institution, give street address or location)                                   |  | A. STATE<br><b>MD.</b>  |  | B. COUNTY<br><b>28-04</b>  |  |
| <b>1003 WALNUT AVE.</b>   |                     |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b>   |  |  |  |
|   |                     |  |  | D. STREET ADDRESS (If rural, give location)<br><b>1003 WALNUT AVE.</b>  |  |  |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                             |  | 8. DATE OF BIRTH<br><b>MAY 7, 1901</b>  | 9. AGE (In years last birthday)<br><b>63</b> | If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.                |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>STEAM FITTER-RET.</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>CONSTRUCTION</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>ALOYSEUS H. RENEHAN</b>   |                     |  |  | 14. MOTHER'S MAIDEN NAME<br><b>MARY I. SELBY</b>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>225-10-1538</b>  |  | 17. INFORMANT ADDRESS<br><b>Mrs Elmer H. Renahan - 1003 Walnut Ave.</b>   |  |  |  |
| 18. I<br><b>4-20-1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Occlusion, Acute</b><br>Sudden<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Hypertensive Arteriosclerotic Heart Disease</b><br>unknown<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                     |  |  | CAUSE OF DEATH<br>(A) <b>Coronary Occlusion, Acute</b><br>DUE TO<br>(B) <b>Hypertensive Arteriosclerotic Heart Disease</b><br>DUE TO<br>(C) |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) <del>(the hospital)</del> attended the deceased from <b>June 19 60</b> to <b>April 19 65</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>March 8, 19 65</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) (did not) view the body after death.  |                     |  |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Leo J. Gaver, M.D.</b>   |                     |  |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>        |  | 23B. DATE SIGNED<br><b>4/7/65</b>                                      |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Leo J. Gaver, M.D.</b>   |                     |  |  | 23D. ADDRESS<br><b>1 Mallow Hill Ave., Baltimore 29, Maryland</b>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>4-9-65</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Cathedral Cem.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>   |                     | 25B. NAME OF REGISTRAR<br><b>R. L. E. Fisher, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>St. Johns Funeral Home - Catonsville, Md.</b>   |  | ADDRESS  |  |



# FUNERAL DIRECTOR: IMPORTANT

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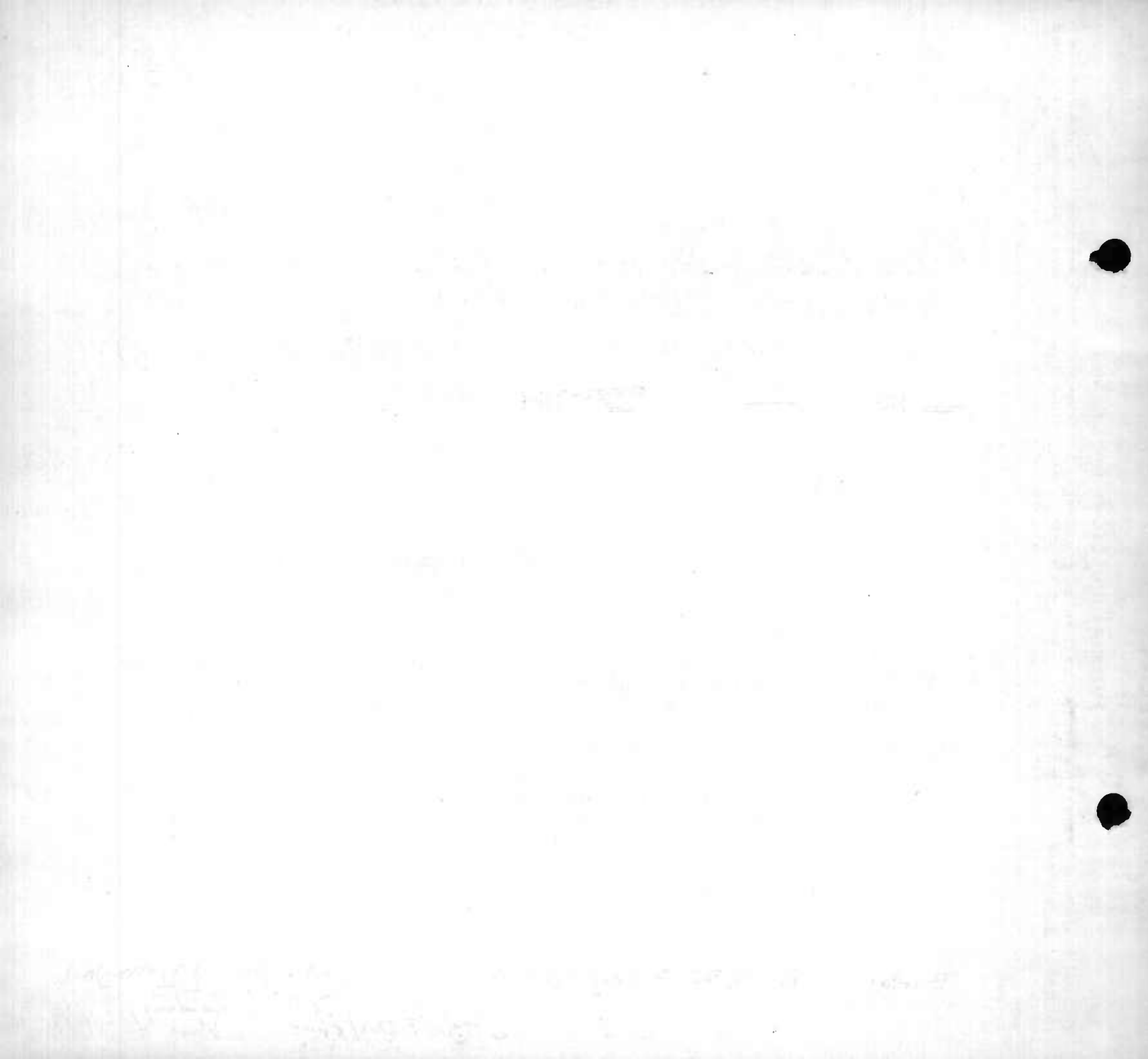
|  |  |  |  |  |  |
|--|--|--|--|--|--|
| BIRTH NO. 65 3869  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3869   |  |
| M.E. CASE NO.  |  | CERTIFICATE OF DEATH   |  | 2. DATE AND HOUR OF DEATH 4-8-65 11:55 A. M.   |  |
| 1. NAME OF DECEASED (Type or Print) Madge Norwitz  |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland, Baltimore B. COUNTY Baltimore |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland #21224  |  | 5. SEX Female  |  | 6. RACE White  |  |
| 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) Widowed  |  | 8. DATE OF BIRTH 9-14-96   |  | 9. AGE (In years last birthday) 68   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife   |  | 10B. KIND OF BUSINESS OR INDUSTRY Own Home   |  | 11. BIRTHPLACE (State or foreign country) Massachusetts  |  |
| 13. FATHER'S NAME John Bennett   |  | 14. MOTHER'S MAIDEN NAME Lucretia Marshall   |  | 12. CITIZEN OF WHAT COUNTRY? U. S. A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) NO   |  | 16. SOCIAL SECURITY NO. 212.20.7327  |  | 17. INFORMANT ADDRESS RECORDS: B.C.H. 4940 Eastern Avenue #21224   |  |
| 18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)   |  | (A) Cerebrovascular Accident   |  | INTERVAL BETWEEN ONSET AND DEATH 6 Months  |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) Arteriosclerotic Cardio Vascular Disease   |  | ???  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | Diabetes Mellitus  |  | Diagnose October 64  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 10-4-19 64 to 4-8-19 65, that (I) (we) lost saw the deceased alive on 4-8-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE Philip Zieve  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED 4-8-65  |  |
| 23C. PHYSICIAN'S NAME (Type) Dr. Philip Zieve  |  | 23D. ADDRESS M.D. 4940 Eastern Avenue #21224   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY Lorraine  |  |
| 24D. LOCATION Baltimore Md.  |  | 24E. LOCATION (City, town, or county) Baltimore  |  | 24F. LOCATION (State) Md.  |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 12 1965  |  | 25B. NAME OF REGISTRAR Robert E. Fagund  |  | 25C. FUNERAL DIRECTOR J.T. Stansbury 6411 Windsor Mill   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

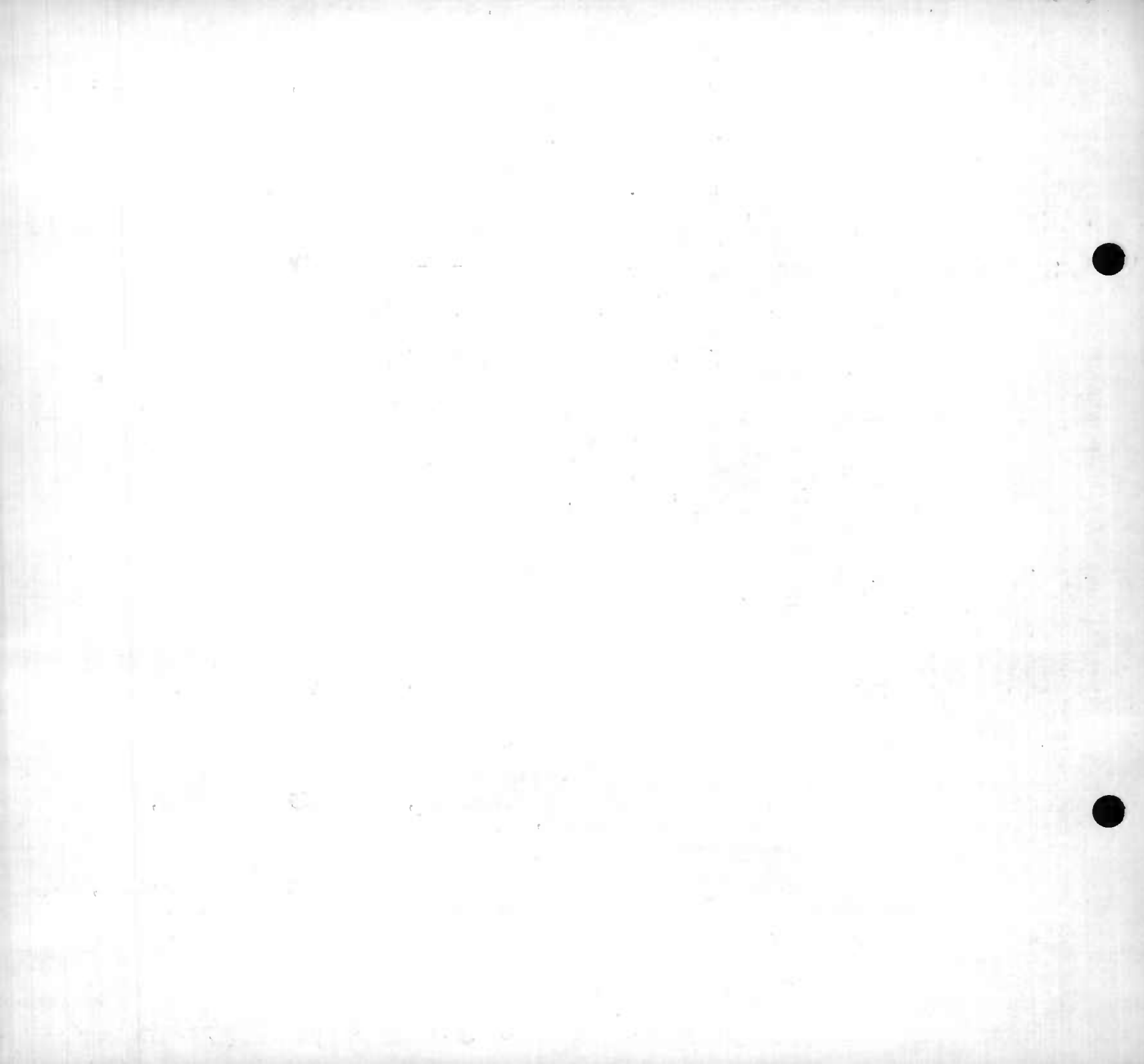
|  |                  |   |                             |  |   |
|--|------------------|---|-----------------------------|--|---|
| BIRTH NO. 65 3870  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                             | Registered No. 65 3870                                     |   |
| M.E. CASE NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) LLOYD NICHOLAS RICHARDSON  |                             | 2. DATE AND HOUR OF DEATH<br>4-9-65 3:45 PM M.             |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>UNION MEMORIAL HOSP   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE B. COUNTY<br>MARYLAND HARFORD<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BEL AIR 62-00<br>D. STREET ADDRESS (If rural, give location)<br>PO BOX 351 BEL AIR  |                             |  |   |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>MARRIED   | 8. DATE OF BIRTH<br>6-12-91 | 9. AGE (In years lost birthday)<br>73                      | If Under 1 Yr. Months: Days: Hours: Min.<br>If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>PHARMACIST  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>PHARMACY   |                             | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND      |   |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA  |                  | 13. FATHER'S NAME<br>JOHN S. RICHARDSON, JR.  |                             | 14. MOTHER'S MAIDEN NAME<br>ELIZABETH C. HARDESTY          |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.<br>215-32-9984  |                             | 17. INFORMANT<br>CHART ADDRESS                             |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) Acute Myocardial Infarction<br>(B) Adv. Scler. Card. Vasc. disease<br>(C) Old Infarction 1961   |                             | INTERVAL BETWEEN ONSET AND DEATH<br>30 min<br>5+ years     |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |   |                             |  |   |
| 19A. DATE OF OPERATION<br>4-9-65   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CARCINOMA OF COLON  |                             | 20A. AUTOPSY? (Yes or No)<br>NO                            |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR? |                             |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from 3-21 19 65 to 4-9 19 65, that (I) (we) last saw the deceased alive on 4-9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                           |                  |   |                             |  |   |
| 23A. SIGNATURE<br>RC Thompson  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                             | 23B. DATE SIGNED<br>4-9-65                                 |   |
| 23C. PHYSICIAN'S NAME (Type)   |                  | 23D. ADDRESS<br>M.D.  |                             |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>April 12, 1965   |                             | 24C. NAME OF CEMETERY or CREMATORY<br>St. Mary's Episcopal |   |
| 24D. LOCATION (City, town, or county) (State)<br>Emmorton, Harford Co, Maryland  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |                             |  |   |
| 25B. NAME OF REGISTRAR<br>Robert E. Thompson   |                  | 25C. FUNERAL DIRECTOR<br>Joseph William Fisher  |                             |  |   |
| 25D. ADDRESS<br>w. Broadway Williams St. Bel Air, Md.  |                  |   |                             |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |               |  |                          |  |  |
|--|---------------|--|--------------------------|--|--|
| BIRTH NO. 65 3871  |               | BALTIMORE CITY HEALTH DEPARTMENT   |                          | Registered No. 65 3871   |  |
| M.E. CASE NO.  |               | CERTIFICATE OF DEATH   |                          |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) Henry Patterson   |               | 2. DATE AND HOUR OF DEATH<br>April 8, 1965 10:40 A.M.  |                          |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Provident Hospital<br>1514 Division Street<br>Baltimore, Maryland   |               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore<br>D. STREET ADDRESS (If rural, give location) Rehobth Nursing Home |                          |  |  |
| 5. SEX Male  | 6. RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) Widowed   | 8. DATE OF BIRTH 6-30-03 | 9. AGE (In years last birthday) 61                                       | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman   |               | 10B. KIND OF BUSINESS OR INDUSTRY  |                          | 11. BIRTHPLACE (State or foreign country) W. Virginia                    |  |
| 12. CITIZEN OF WHAT COUNTRY? USA   |               | 13. FATHER'S NAME James F. Patterson   |                          | 14. MOTHER'S MAIDEN NAME Rebecca Thornton                                |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |               | 16. SOCIAL SECURITY NO. 217-14-5381  |                          | 17. INFORMANT ADDRESS Peachie Johnson 701 Reservoir St.                  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>Pulmonary embolism  |               | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO above the knee amputation of left leg<br>(C) Generalized arteriosclerosis   |                          | INTERVAL BETWEEN ONSET AND DEATH   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |               |  |                          |  |  |
| 19A. DATE OF OPERATION 4-2-65  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Gangrene left foot.   |                          | 20A. AUTOPSY? (Yes or No) Yes.   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>   |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                          | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 19, 1965 to April 8, 1965, that (I) (we) last saw the deceased alive on April 8, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |  |                          |  |  |
| 23A. SIGNATURE Delfin David  |               | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                          | 23B. DATE SIGNED April 9, 1965   |  |
| 23C. PHYSICIAN'S NAME (Type) Delfin David  |               | 23D. ADDRESS 1514 Division Street  |                          |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |               | 24B. DATE 4-13-65  |                          | 24C. NAME OF CEMETERY or CREMATORY Mt. Auburn                            |  |
| 24D. LOCATION (City, town, or county) Balto.   |               | 24E. (State) Md.   |                          |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 12 1965  |               | 25B. NAME OF REGISTRAR   |                          | 25C. FUNERAL DIRECTOR ADDRESS Moctar Dyett 916 Penna. Ave.               |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |         | BALTIMORE CITY HEALTH DEPARTMENT   |                  | Registered No.   |                             |
|---|---------|--|------------------|--|-----------------------------|
| 65 3872   |         | CERTIFICATE OF DEATH   |                  | 65 3872  |                             |
| M.E. CASE NO.   |         | 1. NAME OF DECEASED  |                  | 2. DATE AND HOUR OF DEATH  |                             |
|   |         | Berry, HERMAN EUGENE   |                  | 4/10/65 4:40 PM  |                             |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                  | A. STATE   |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |         | Maryland   |                  | B. COUNTY  |                             |
| 44 Union Memorial Hospital  |         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |                  | Baltimore  |                             |
|   |         | D. STREET ADDRESS (If rural, give location)  |                  | 4745 Ivanhoe Avenue  |                             |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. Under 1 Yr. Months Days |
| M   | NEGRO   | MARRIED  | 11-14-42         | 22 years   |                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |                             |
| Florist   |         | Floral Shop  |                  | Maryland   |                             |
| 13. FATHER'S NAME   |         | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |                             |
| ROBERT LEE BERRY  |         | Lena Whye  |                  | American   |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT  |                             |
|   |         | 219-42-1201  |                  | J. M. Anandiah   |                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         | CAUSE OF DEATH   |                  | INTERVAL BETWEEN ONSET AND DEATH   |                             |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |         | (A) Diffuse primary liver cell carcinoma with metastasis to periportal nodes and lungs.  |                  | 3 29 65  |                             |
| ANTECEDENT CAUSES   |         | (B) DUE TO   |                  | 4 10 65  |                             |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         | (C)  |                  |  |                             |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |         | Obstructive jaundice due to I  |                  |  |                             |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |                             |
| 3/12/65   |         | Exploratory laparotomy + liver biopsy  |                  | Yes  |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                             |
|   |         |  |                  |  |                             |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?   |                             |
| (Month) (Day) (Year) (Hour)   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                  |  |                             |
| 22. I certify that (I) (this hospital) attended the deceased from 3 29 65 to 4 10 65, that (I) (we) last saw the deceased alive on 4 10 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |  |                             |
| 23A. SIGNATURE  |         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                  | 23B. DATE SIGNED   |                             |
| K-M. Anandiah   |         |  |                  | 4 10 65  |                             |
| 23C. PHYSICIAN'S NAME (Type)  |         | 23D. ADDRESS   |                  |  |                             |
| K. M. ANANDIAH  |         | Union Memorial Hospital Baltimore Md.  |                  |  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |                             |
| Burial  |         | 4-14-65  |                  | St. Luke M.E. Church Con.  |                             |
|   |         |  |                  | 24D. LOCATION (City, town, or county) (State)                            |                             |
|   |         |  |                  | Reisterstown Md.   |                             |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR  |                             |
| APR 12 1965   |         | Robert E. Taylor   |                  | Mortimer Dyett   |                             |
|   |         |  |                  | ADDRESS  |                             |
|   |         |  |                  | 916 Penna Ave.   |                             |

THE END

BIRTH NO. 65 3873 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3873

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

CHARLES NORMAN

2. DATE AND HOUR PRONOUNCED DEAD

April 6, 1965

12:50 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1108 Federal St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

SINGLE

8. DATE OF BIRTH

3 3 1952

9. AGE (In years  
last birthday)

13

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

Student

11. BIRTHPLACE (State or foreign country)

Balto. Md.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

John Irvin

Arbett

14. MOTHER'S MAIDEN NAME

MAE BELL MAKINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown. (If yes, give war or dates of service))

NO

16. SOCIAL  
SECURITY NO.

NO

17. INFORMANT

ADDRESS

MAE BELL MAKINS 1108 FEDERAL ST.

18.

E 914.13

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Severe body burns  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Electrocutation  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Tunnel

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Old union tunnel, north of Penn Station

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 6 65 10:02a

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

Apparently touched overhead railroad

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

wire.

ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-7-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-9-65

23C. NAME of CEMETERY or CREMATORY

MT. ARBURN Cem.

23D. LOCATION

(City, town, or county)

(State)

BALTO. MD

24A. DATE REC'D BY HEALTH DEPT.

APR 12 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

MARSHALL W. JONES, JR.

ADDRESS

1735-37  
HARFORD AVE.

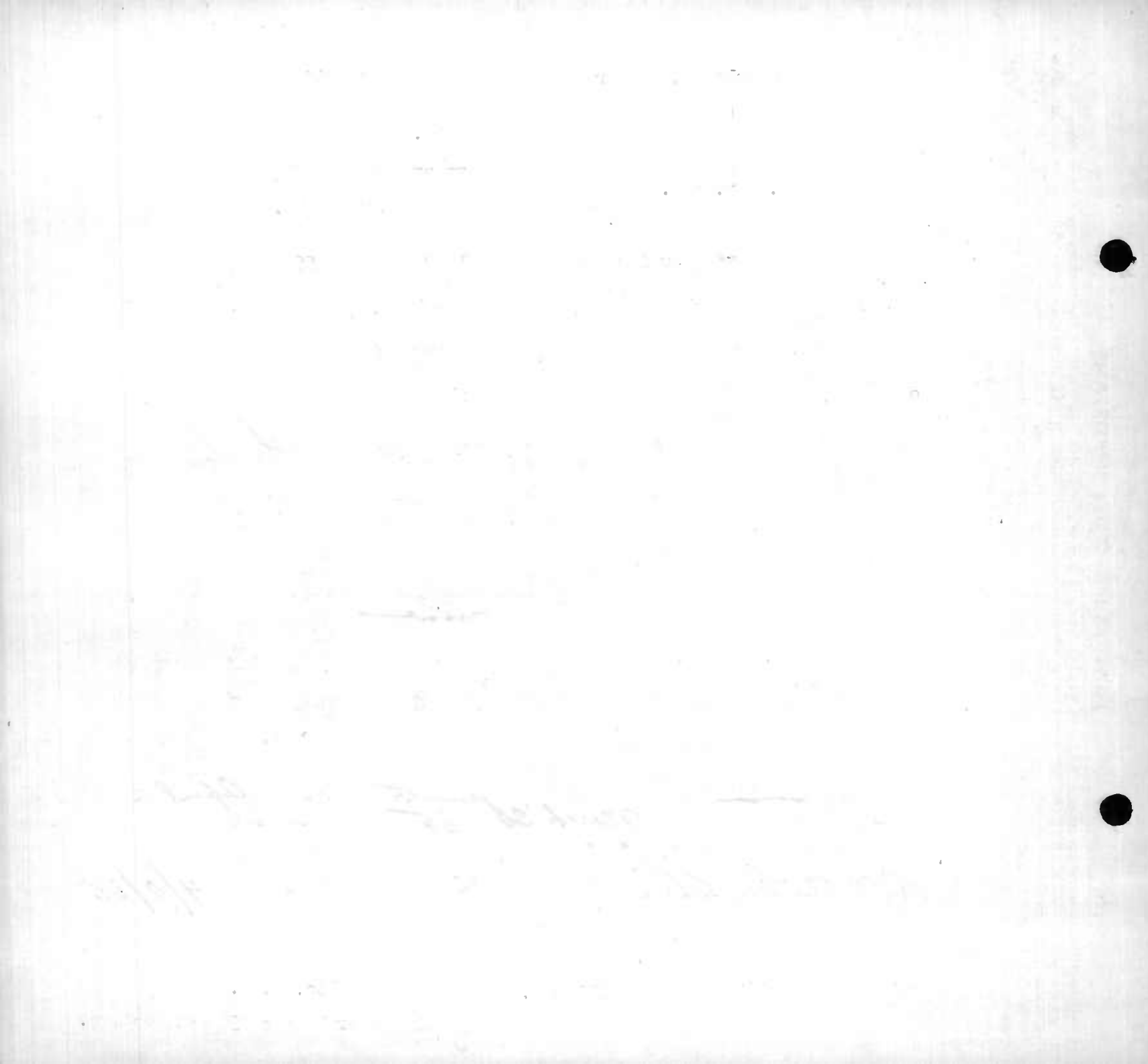
VALLEY FORD

*[Handwritten signature]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3874   |              |   |                             | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3874   |  |
|---|--------------|---|-----------------------------|---|--|--|--|
| M.E. CASE NO.   |              |   |                             | CERTIFICATE OF DEATH  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) Charles A. Snyder  |              |   |                             | 2. DATE AND HOUR OF DEATH<br>4/2/65   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><br>Md. Gen. Hosp.   |              |   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY AA<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Balti Green Haven<br>D. STREET ADDRESS (If rural, give location)<br>Catherine Ave. |  |  |  |
| 5. SEX<br>M   | 6. RACE<br>W | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married                                       | 8. DATE OF BIRTH<br>9/19/09 | 9. AGE (In years last birthday)<br>55   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Optician   |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Self   |                             | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br>Frank Snyder   |              |   |                             | 14. MOTHER'S MAIDEN NAME<br>Mary Stickels   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |              | 16. SOCIAL SECURITY NO.   |                             | 17. INFORMANT<br>Family   |  | ADDRESS<br>Same  |  |
| 18. 420.1 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |              |   |                             | CAUSE OF DEATH<br>(A) DUE TO<br>Acute Coronary Thrombosis<br>(B) DUE TO<br>Coronary arteriosclerotic heart disease<br>(C)<br><br>INTERVAL BETWEEN ONSET AND DEATH<br>30 minutes<br>3 years.   |  |  |  |
| 19A. DATE OF OPERATION  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                             | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                             | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from June 15 1950 to April 2 1965, that (I) (we) last saw the deceased alive on March 30 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |              |   |                             |   |  |  |  |
| 23A. SIGNATURE<br>R.M. McLaughlin   |              |   |                             | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |  | 23B. DATE SIGNED<br>4/9/65   |  |
| 23C. PHYSICIAN'S NAME (Type)  |              |   |                             | 23D. ADDRESS<br>M.D.  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |              | 24B. DATE<br>4/6/65   |                             | 24C. NAME of CEMETERY or CREMATORY<br>Cedar Hill Cem.   |  | 24D. LOCATION (City, town, or county) (State)<br>Balto. 25, d.       |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |              | 25B. NAME OF REGISTRAR<br>Robert E. Farkner   |                             | 25C. FUNERAL DIRECTOR<br>McCully Funeral Home   |  | ADDRESS<br>237 Patspeco Ave.   |  |

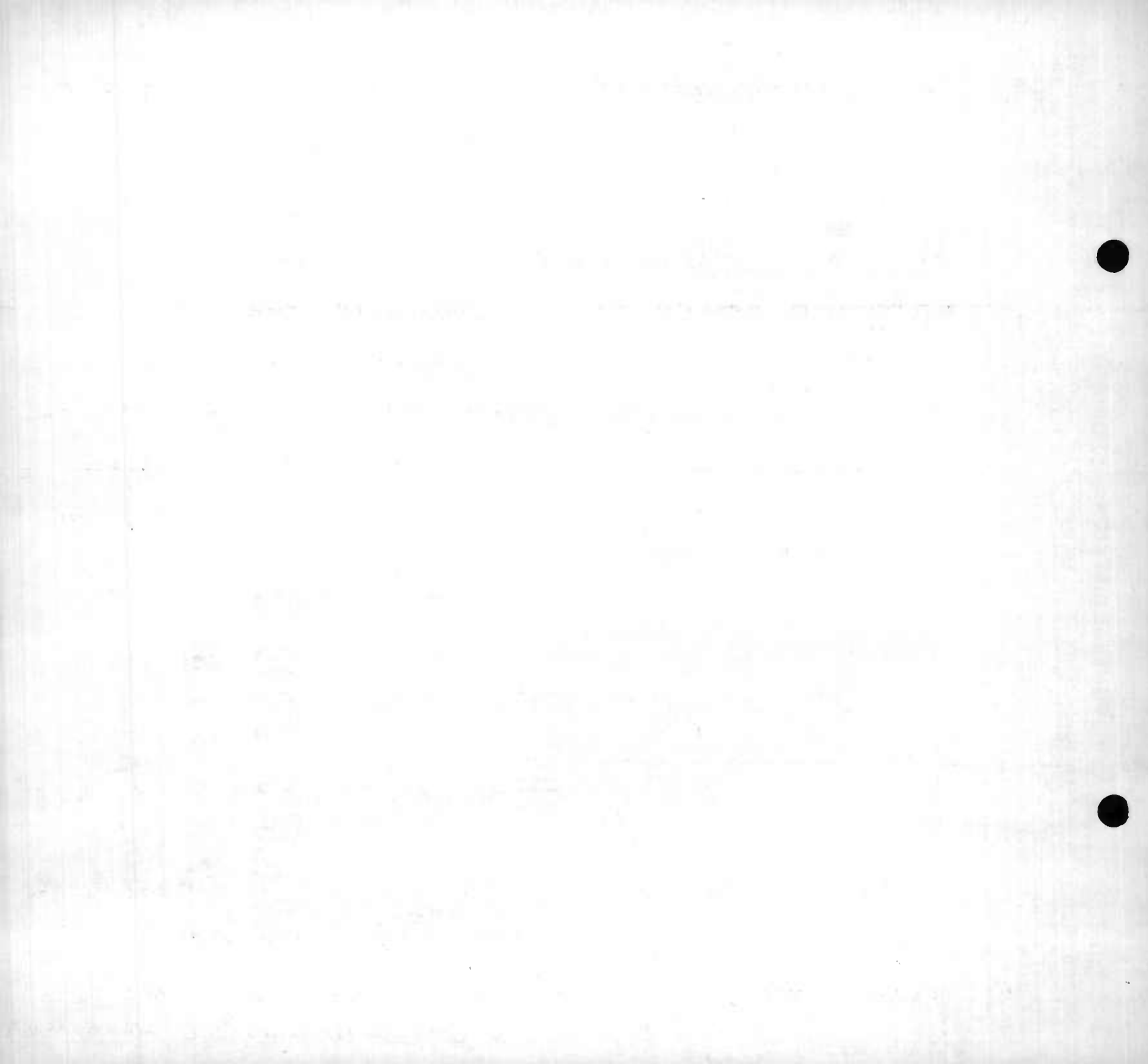


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3875  |                     |   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3875   |  |
|--|---------------------|---|--|--|--|--|--|
| M.E. CASE NO.  |                     |   |  | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>STUART HEYMAN</b>  |                     |   |  | 2. DATE AND HOUR OF DEATH<br><b>4-8-65 4:15 P. M.</b>  |  |  |  |
| 3. PLACE OF DEATH IN <b>BALTIMORE, MARYLAND</b>  |                     |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTO</b>   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>ESPLANADE APTS 2525 EUTAW PL</b>   |                     |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTO</b>  |  |  |  |
|  |                     |   |  | D. STREET ADDRESS (If rural, give location)<br><b>ESPLANADE APTS</b>   |  |  |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>NEVER MARRIED</b>  | B. DATE OF BIRTH<br><b>AUG. 31-1880</b>                          | 9. AGE (In years lost birthday)<br><b>84</b>   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MERCHANDISE BROKER</b>   |                     |   | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE MD</b> |  | 12. CITIZEN OF WHAT COUNTRY?                           |  |  |
| 13. FATHER'S NAME<br><b>JONAS.</b>   |                     |   | 14. MOTHER'S MAIDEN NAME<br><b>LAURA</b>                         |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     |   | 16. SOCIAL SECURITY NO.<br><b>216-32-9868</b>                    |  | 17. INFORMANT<br><b>MRS LEON LEVI</b>                  |  |  |
|  |                     |   | ADDRESS<br><b>2525 EUTAW PL</b>                                  |  |  |  |  |
| 18. <b>260 X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>SENILITY</b>  |                     |   |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>5 years</b>                   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>DIABETES MELLITUS</b>   |                     |   |  | (B) DUE TO   |  | <b>3 years</b>   |  |
|  |                     |   |  | (C) <b>Pyelo-Nephritis</b>   |  | <b>3 years</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |   |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Home <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 1 1961</b> to <b>April 8 1965</b> , that (I) (we) last saw the deceased alive on <b>April 8 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Erwin E. Mayer</b>  |                     |   |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><b>April 9, 1965</b>                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ERWIN E. MAYER</b>  |                     |   |  | 23D. ADDRESS<br><b>2525 EUTAW PLACE THE ESPLANADE APTS</b>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                     | 24B. DATE<br><b>4-9-65</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>OHED SHALOM</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MD</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Jankovics</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Black &amp; Lewis Inc</b>  |  | ADDRESS<br><b>2100 EUTAW PL</b>                                      |  |







BIRTH NO.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

ELEANOR A. MARKELL

2. DATE AND HOUR PRONOUNCED DEAD

4/8/65 9:00 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

103 W. 39th St.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Sept. 19, 1904

9. AGE (In years  
last birthday)

60

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Home

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

George S. Harlan

14. MOTHER'S MAIDEN NAME

Ellen McIntyre

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mr. Oscar M. Lemoine 4239 Wickford Rd.

18. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Fatty liver

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

W. U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/9/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-12-65

23C. NAME of CEMETERY or CREMATORY

Mt. Olivet

23D. LOCATION

(City, town, or county)

(State)

Frederick, Maryland

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 12 1965

John O. Mitchell &amp; Sons, Inc.

1900 Eutaw Place Baltimore, Md.

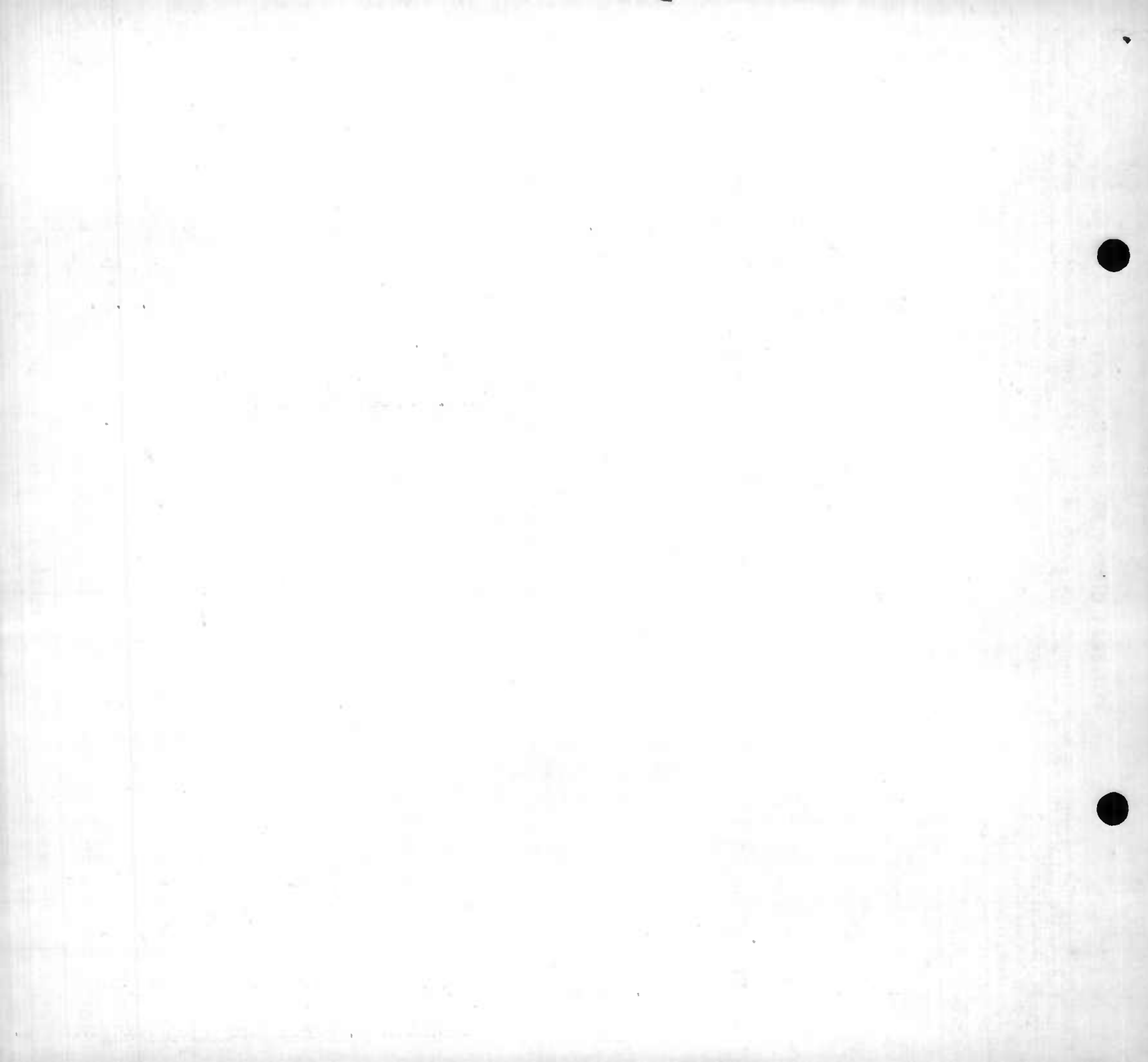
WALTER H. HIGGINS

2nd 1st 1st 1st

# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                        |   |                                     | Registered No. <span style="font-size: 1.5em;">65 3877</span>  |  |
|--|------------------------|---|-------------------------------------|--|--|
| BIRTH NO. <span style="font-size: 1.5em;">65 3877</span>   |                        | <b>CERTIFICATE OF DEATH</b>   |                                     |  |  |
| M.E. CASE NO.  |                        | 1. NAME OF DECEASED<br>(Type or Print) <i>Ann (ANNA) C. Stewart</i>   |                                     | 2. DATE AND HOUR OF DEATH<br><i>4-9-65 11:30 p.m.</i>  |  |
| 3. PLACE OF DEATH IN <i>BALTIMORE, MARYLAND</i>  |                        | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                                     |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Union Memorial Hospital</i>   |                        | A. STATE <i>Maryland</i> B. COUNTY <i>Hartford</i>  |                                     |  |  |
| (If not in hospital or institution, give street address or location)   |                        | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Fallston 62-00</i>  |                                     |  |  |
|  |                        | D. STREET ADDRESS (If rural, give location)<br><i>Rt # 1 Hartford Road.</i>   |                                     |  |  |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>Cauc</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Widowed</i>  | 8. DATE OF BIRTH<br><i>11-29-83</i> | 9. AGE (In years last birthday)<br><i>81</i>   | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                        | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>New York</i>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |                        | 13. FATHER'S NAME<br><i>FRANK Michon</i>  |                                     | 14. MOTHER'S MAIDEN NAME<br><i>Mary Boers</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                        | 16. SOCIAL SECURITY NO.   |                                     | 17. INFORMANT (Name)<br><i>Mrs. Helen Macaulay</i>   |  |
| 18. <i>434.1 I</i>   |                        | CAUSE OF DEATH  |                                     | INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |                        | (A) <i>Pleural effusion</i><br>DUE TO   |                                     | <i>1 - day</i>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                        | (B) <i>Congestive Heart failure.</i><br>DUE TO  |                                     | <i>2 weeks.</i>  |  |
| (C) _____  |                        |   |                                     |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                        |   |                                     |  |  |
| 19A. DATE OF OPERATION   |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                        | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                        | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?   |                        | 22. I certify that (I) (this hospital) attended the deceased from <i>4-9-65</i> 19 to <i>4-9</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4-9</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                                     |  |  |
| 23A. SIGNATURE<br><i>Rodney L. Brimhall</i> M.D.   |                        | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                                     | 23B. DATE SIGNED<br><i>4-9-65</i>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Rodney L. Brimhall</i>  |                        | 23D. ADDRESS<br><i>Union Memorial Hospital.</i>   |                                     |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                        | 24B. DATE   |                                     | 24C. NAME of CEMETERY or CREMATORY<br><i>St. John's Cemetery</i>                                       |  |
| 24D. LOCATION (City, town, or county) (State)<br><i>North Troy, New York</i>   |                        | 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 12 1965</i>   |                                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor, M.D.</i>  |  |
| 25C. FUNERAL DIRECTOR<br><i>Leonard J. Ruck Inc</i>  |                        | ADDRESS<br><i>5305 Hartford Rd.</i>   |                                     |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

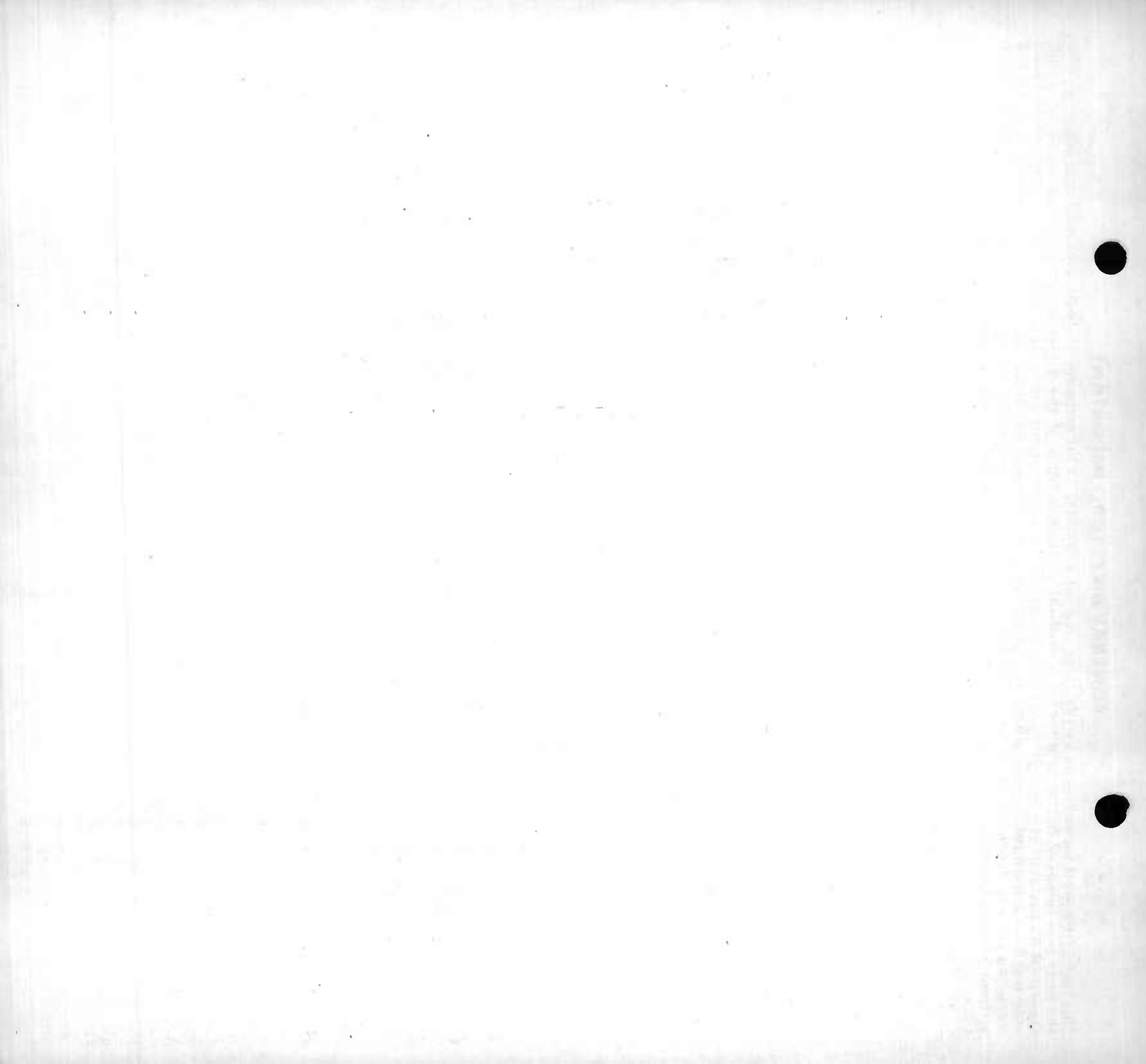
| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | BIRTH NO. 65 3878   |  | CERTIFICATE OF DEATH   |  | Registered No. 65 3878           |  |
|---|--|--|--|---|--|--|--|----------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |  |  |  | 2. DATE AND HOUR OF DEATH   |  |  |  |                                  |  |
| FRAZIER, BARBARA  |  |  |  | April 9, 1965   |  | 11:35 P.   |  | M.                               |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |  |                                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |  |  |  | A. STATE  |  | B. COUNTY  |  |                                  |  |
| ST. JOSEPH HOSPITAL   |  |  |  | Md.   |  | Baltimore  |  | 6                                |  |
|   |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  | Baltimore  |  | 6                                |  |
|   |  |  |  | D. STREET ADDRESS (If rural, give location)   |  | 18 W. Elm Avenue   |  | 5300                             |  |
| 5. SEX  |  | 6. RACE  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                |  | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)  |  |
| Female  |  | White  |  | Married   |  | 1/20/06  |  | 59                               |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)                            |  | 12. CITIZEN OF WHAT COUNTRY?     |  |
| Housewife   |  |  |  |   |  | Maryland   |  | U.S.A.                           |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |                                  |  |
| Christopher Link  |  |  |  | Barbara Rodert  |  |  |  |                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS                          |  |
|   |  |  |  |   |  | Mr. Matthew J. Frazier   |  | same                             |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  |  | CAUSE OF DEATH  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)  |  |  |  | (A) DUE TO  |  |  |  |                                  |  |
| ANTECEDENT CAUSES   |  |  |  | (B) DUE TO  |  |  |  |                                  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | (C) DUE TO  |  |  |  |                                  |  |
| II  |  |  |  |   |  |  |  |                                  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |   |  |  |  |                                  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                  |  |
| 0   |  |  |  | No  |  |  |  |                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |                                  |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |                                  |  |
| (Month) (Day) (Year) (Hour)   |  | While At Work <input type="checkbox"/> At Work <input type="checkbox"/>                  |  |   |  |  |  |                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3/24 1965 to 4/9 1965, that (I) (we) last saw the deceased alive on 4/9 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |  |  |                                  |  |
| 23A. SIGNATURE  |  |  |  | 23B. DATE SIGNED  |  |  |  |                                  |  |
| Manuel A. Gongon  |  |  |  | 4/9/65  |  |  |  |                                  |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |  |  | 23D. ADDRESS  |  |  |  |                                  |  |
| Manuel A. Gongon  |  |  |  | 1400 N. Caroline Street   |  |  |  |                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                        |  |                                  |  |
| Burial  |  | 4/13/65  |  | Gardens of Faith Cem.   |  | Baltimore, Maryland  |  |                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS  |  |                                  |  |
| APR 12 1965   |  | Robert E. Taylor   |  | Leonard J. Ruck Inc   |  | 5305 Harford Rd.   |  |                                  |  |

James A. Smith

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

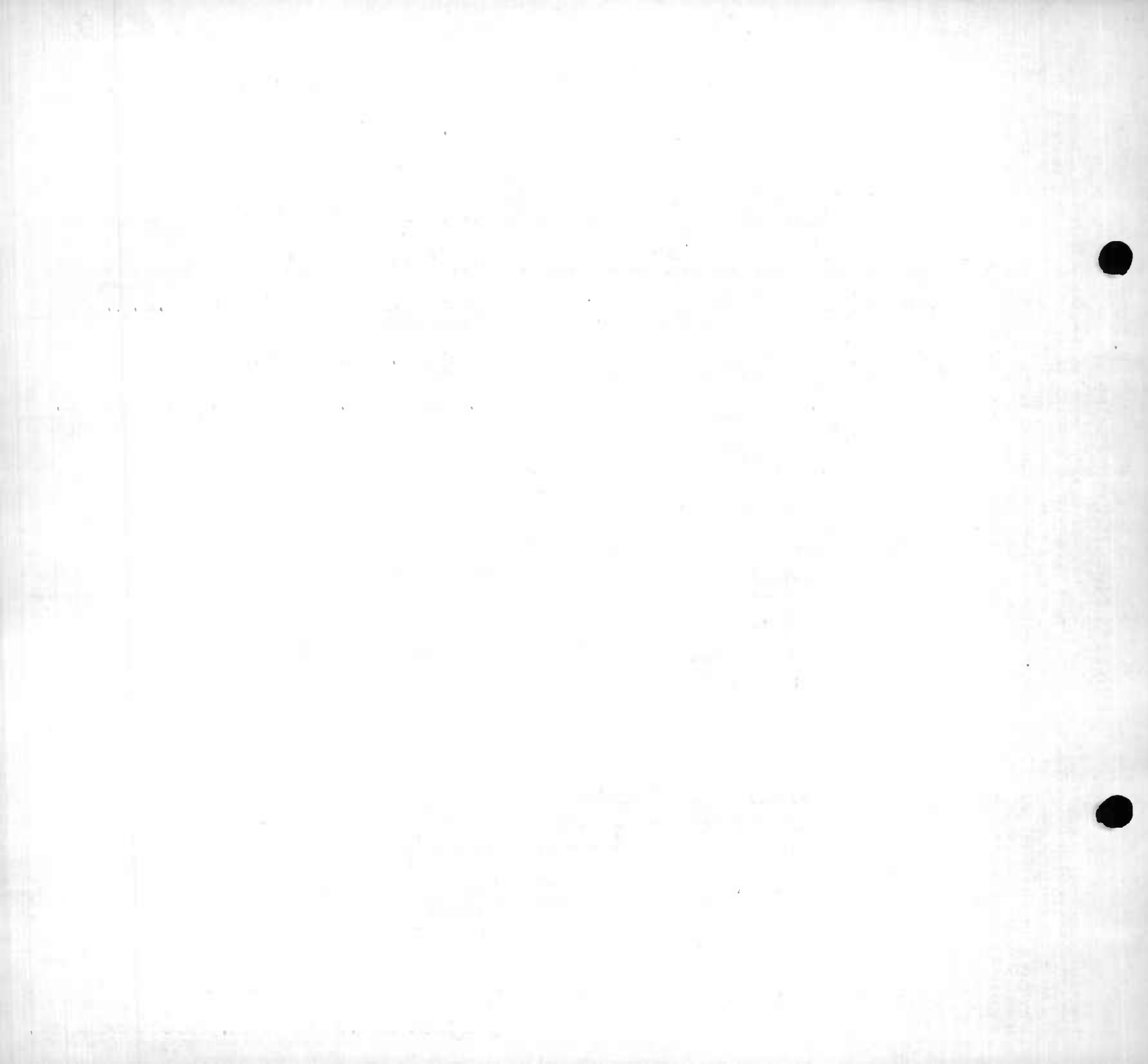
|   |                  |  |                                   |  |   |
|---|------------------|--|-----------------------------------|--|---|
| BIRTH NO. 65 3879   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |                                   | Registered No. 65 3879   |   |
| M.E. CASE NO.   |                  | 1. NAME OF DECEASED<br>(Type at Print) Robert G. Cook  |                                   | 2. DATE AND HOUR OF DEATH<br>April 9, 1965 2 PM M.                                   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 27-05           |                                   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>44 Union Memorial Hospital   |                  | D. STREET ADDRESS (If rural, give location)<br>3218 Rosalie Avenue   |                                   |  |   |
| 5. SEX<br>male  | 6. RACE<br>white | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>married  | 8. DATE OF BIRTH<br>Oct. 27, 1919 | 9. AGE (In years last birthday)<br>45  | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Inspt. Civil Service   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                   | 11. BIRTHPLACE (State or foreign country)<br>Texas                                   |   |
| 13. FATHER'S NAME<br>Henry Cook   |                  | 14. MOTHER'S MAIDEN NAME<br>Jean Gilmore   |                                   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO.<br>454-07-1898   |                                   | 17. INFORMANT<br>Mrs. Elizabeth Cook, same ADDRESS                                   |   |
| 18. 420.1 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>Ventricular fibrillation<br>Myocardial infarction                      |                  | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C)  |                                   | INTERVAL BETWEEN ONSET AND DEATH<br>Minutes.<br>acute                                |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                  |  |                                   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |  |                                   |  |   |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |   |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                                   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 1940 to 4/9/65 that (I) (we) last saw the deceased alive on 4/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. |                  |  |                                   |  |   |
| 23A. SIGNATURE<br>Walter E. Karggin   |                  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                   | 23B. DATE SIGNED<br>4/10/65  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Walter E. Karggin   |                  | 23D. ADDRESS<br>4331 Harford Road  |                                   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4/13/65   |                                   | 24C. NAME OF CEMETERY or CREMATORY<br>Dulaney Valley Mem Pk                          |   |
| 24D. LOCATION<br>Baltimore, Maryland  |                  |  |                                   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Faley  |                                   | 25C. FUNERAL DIRECTOR<br>L. J. Ruck Inc 5305 Harford Rd.                             |   |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

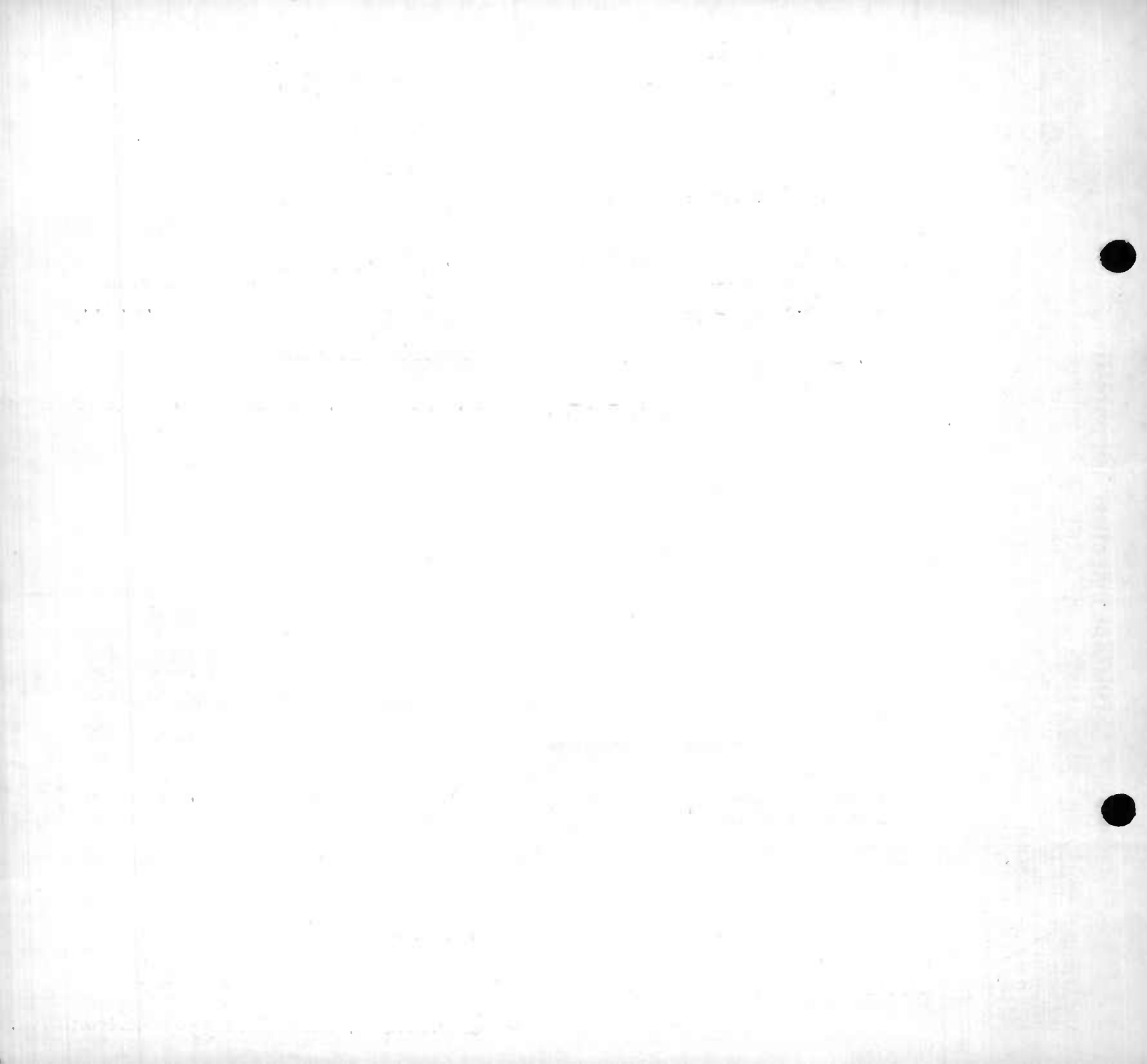
|  |                             |  |                                     |  |   |
|--|-----------------------------|--|-------------------------------------|--|---|
| BIRTH NO. <span style="font-size: 2em;">65 3880</span>   |                             | <b>CERTIFICATE OF DEATH</b>  |                                     | Registered No. <span style="font-size: 2em;">65 3880</span>  |   |
| M.E. CASE NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <i>Irene Marguerite Bowen</i>   |                                     | 2. DATE AND HOUR OF DEATH<br><i>April 8, 1965</i> <span style="float: right;">9 P. M.</span>             |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY <i>12-22</i>  |                                     | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>              |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>3047 Guilford Avenue</i>  |                             | D. STREET ADDRESS (If rural, give location)<br><i>3047 Guilford Avenue</i>   |                                     |  |   |
| 5. SEX<br><i>Female</i>  | 6. RACE<br><i>White</i>     | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><i>Widowed</i>   | 8. DATE OF BIRTH<br><i>4/8/1894</i> | 9. AGE (In years last birthday)<br><i>71</i>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>   | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>             |
| 13. FATHER'S NAME<br><i>John Philip Style</i>  |                             | 14. MOTHER'S MAIDEN NAME<br><i>Mary R. Weisbecker</i>  |                                     | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |   |
| 16. SOCIAL SECURITY NO.  |                             | 17. INFORMANT<br><i>Mr. Albert R. Bowen, 619 Hollen Rd.</i>  |                                     | ADDRESS  |   |
| 18. <i>4-20-1</i> I  |                             | CAUSE OF DEATH   |                                     | INTERVAL BETWEEN ONSET AND DEATH   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |                             | (A) <i>Coronary Thrombosis</i><br>DUE TO   |                                     | <i>1 day</i>   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                             | (B) <i>Chronic sclerotic Cardio</i><br>DUE TO  |                                     | <i>5 yrs</i>   |   |
|  |                             | (C) <i>Vascular Disease - Hypertension</i>   |                                     |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                             |  |                                     |  |   |
| 19A. DATE OF OPERATION<br><i>0</i>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (natally medical examiner) <input type="checkbox"/>  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                 |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                                     | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>January 4</i> 19 <i>60</i> to <i>April 8</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>April 5</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |  |                                     |  |   |
| 23A. SIGNATURE<br><i>Chas. W. Edmunds</i>  |                             | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                                     | 23B. DATE SIGNED<br><i>April 10, 1965</i>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Chas. W. Edmunds</i>  |                             | 23D. ADDRESS<br><i>2746 The Alameda Md</i>   |                                     |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  | 24B. DATE<br><i>4/12/65</i> | 24C. NAME of CEMETERY or CREMATORY<br><i>Moreland Memorial Park</i>  |                                     | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Maryland</i>                              |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 12 1965</i>  |                             | 25B. NAME OF REGISTRAR<br><i>Robert E. Johnson</i>   |                                     | 25C. FUNERAL DIRECTOR<br><i>Leonard J. Ruck, Inc., Baltimore, Md.</i>                                    |   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |  |  |  |  |   |  |  |  | Registered No. <b>65 3881</b> |
|--|-------------------------|--|--|--|--|---|--|--|--|-------------------------------|
| BIRTH NO. <b>65 3881</b>   |                         | <b>CERTIFICATE OF DEATH</b>  |  |  |  |   |  |  |  |                               |
| M.E. CASE NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Katherine<br/>(Kathryn Anna Moylan)</b>                      |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>April 9, 1965 4:15 P. M.</b>  |  |  |  |                               |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                         |  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>27-85</b> |  |  |  |                               |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>3210 Woodhome Avenue</b>   |                         |  |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>   |  |  |  |                               |
|  |                         |  |  |  |  | D. STREET ADDRESS (If rural, give location)<br><b>3210 Woodhome Avenue</b>  |  |  |  |                               |
| 5. SEX<br><b>female</b>  | 6. RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED, (specify)<br><b>married</b>                            |  | 8. DATE OF BIRTH<br><b>Apr. 22, 1907</b>                                 | 9. AGE (In years last birthday)<br><b>57</b> | If Under 1 Yr. Months: Days: Hours: Min.  |  | If Under 24 Hrs. Hours: Min.                   |  |                               |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Operator Clothing Factory</b>  |                         |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A..</b> |  |                               |
| 13. FATHER'S NAME<br><b>James R. Fink</b>  |                         |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Catherine Loewenstein</b>                 |  |   |  |  |  |                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                         |  |  | 16. SOCIAL SECURITY NO.<br><b>215-01-7420</b>                            |  | 17. INFORMANT ADDRESS<br><b>Mr. Harvey W. Moylan 3210 Woodhome Av</b>   |  |  |  |                               |
| 18. CAUSE OF DEATH   |                         |  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>1961</b>   |  |  |  |                               |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma, Stomach</b>  |                         |  |  |  |  | (A) DUE TO  |  |  |  |                               |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                         |  |  |  |  | (B) DUE TO  |  |  |  |                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |  |  |  | (C)   |  |  |  |                               |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |  |  |  |                               |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |  |  |                               |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>5/30</b> 19 <b>60</b> to <b>4/9</b> 19 <b>65</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>4/5</b> 19 <b>65</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |  |  |  |   |  |  |  |                               |
| 23A. SIGNATURE<br><b>Nathan Janney</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |                         |  |  |  |  | 23B. DATE SIGNED<br><b>4/10/65</b>  |  |  |  |                               |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Nathan Janney</b> M.D.  |                         |  |  |  |  | 23D. ADDRESS<br><b>7101 Harford Road</b>  |  |  |  |                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4/13/65</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>        |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |  |  |                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Fink</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc</b>                      |  | ADDRESS<br><b>5305 Harford Rd.</b>  |  |  |  |                               |



BIRTH NO.

65 3882

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65 3882

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Jesse (JESSIE) MILLER

2. DATE AND HOUR PRONOUNCED DEAD

4/10/65 12:55 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Union Memorial Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3028 Westfield Ave.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

married

8. DATE OF BIRTH

Apr. 21, 1898

9. AGE (In years  
last birthday)

66

If Under 1 Yr. If Under 24 Hrs.  
Months, Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Retired

10B. KIND OF BUSINESS OR INDUSTRY

S.S. Sup.

11. BIRTHPLACE (State or foreign country)

Westchester, Penna

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Miller

14. MOTHER'S MAIDEN NAME

Hempel

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

145-01-0485

17. INFORMANT

Mrs. Ruth D. Miller

ADDRESS

same

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) Arteriosclerotic cardiovascular disease

DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) Lung cancer (by history)

DUE TO

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

no

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/10/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/13/65

23C. NAME OF CEMETERY or CREMATORY

Baltimore National

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 12 1965

24B. NAME OF REGISTRAR

Robert E. Fisher M.D.

24C. FUNERAL DIRECTOR

Leonard J. Ruck Inc 5305 Harford Rd.

ADDRESS

VALLEY FORD

VALLEY FORD

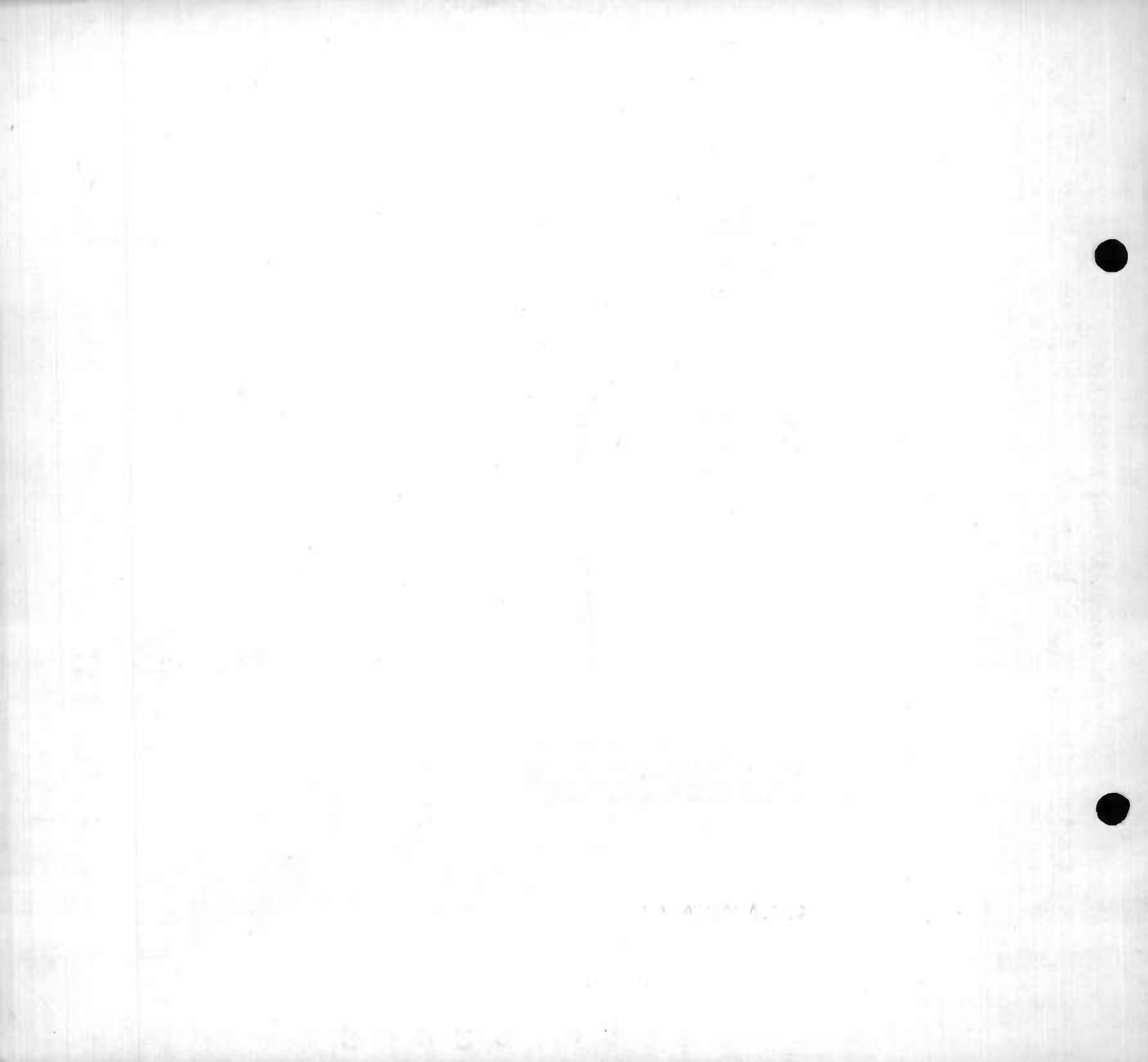
VALLEY FORD

Approved by the Medical Examiner on approval, at 1 AM. 4/11/65

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made. 4

|  |  |  |  |  |  |  |  |                                    |  |
|--|--|--|--|--|--|--|--|------------------------------------|--|
| BIRTH NO.  |  | 65 3883  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No.   |  | 65 3883                            |  |
| M.E. CASE NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  |  |  |                                    |  |
|  |  | JOHNSON, PAUL, JR.   |  | 4/11/65 12-45AM  |  |  |  |                                    |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)    |  |  |  |  |  |                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION   |  | A. STATE   |  | B. COUNTY  |  |  |  |                                    |  |
| Union Memorial Hospital  |  | Maryland   |  | Baltimore  |  |  |  |                                    |  |
|  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                  |  |  |  |  |  |                                    |  |
|  |  | D. STREET ADDRESS (If rural, give location)  |  |  |  |  |  |                                    |  |
|  |  | 2618 Kirk Avenue   |  |  |  |  |  |                                    |  |
| 5. SEX   |  | 6. RACE  |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)                 |  | 8. DATE OF BIRTH   |  | 9. AGE (In years<br>last birthday) |  |
| Male   |  | Negro  |  | Married  |  | 9-12-31  |  | 33 yrs                             |  |
| 10A. USUAL OCCUPATION (Give kind of work<br>done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                |  | 12. CITIZEN OF<br>WHAT COUNTRY?                                      |  |                                    |  |
| Laborer  |  | Bethlehem Steel  |  | N. Carolina  |  | American   |  |                                    |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  |  |  |  |  |                                    |  |
| Joshua Johnson   |  | ROWENA Little  |  |  |  |  |  |                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)                                  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS  |  |                                    |  |
| Unknown  |  | 212-112-5361   |  | K. M. Anandiah   |  | Union Memorial Hospital  |  |                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY<br>LEADING TO DEATH  |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN<br>ONSET AND DEATH                                      |  |  |  |                                    |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) |  | Burns II x III degree 50% of body surface  |  | 3-21-65  |  |  |  |                                    |  |
| ANTECEDENT CAUSES  |  | DUE TO   |  | DUE TO   |  |  |  |                                    |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                    |  | possible Septicemia & Renal failure  |  | 4-11-65  |  |  |  |                                    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                               |  |  |  |  |  |  |  |                                    |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |                                    |  |
| 13/22/65   |  | pre-renal renal edema  |  | No   |  |  |  |                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |                                    |  |
|  |  | Home   |  | 2618 Kirk ave 9-05   |  |  |  |                                    |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |                                    |  |
| 3-21-1965 5AM  |  | While At Work  |  | Burned by cigarette on bed while fall asleep                             |  |  |  |                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from  |  | 3-21-1965  |  | to   |  | 4-11-1965  |  |                                    |  |
| that (I) (we) last saw the deceased alive on   |  | 4-10-1965  |  | and that in (my) (our) opinion death occurred on the date                |  |  |  |                                    |  |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |  |  |  |  |                                    |  |
| 23A. SIGNATURE   |  | M.D. Attending Phys.   |  | Med. Director  |  | Staff Phys.  |  | 23B. DATE SIGNED                   |  |
| K. M. Anandiah   |  |  |  |  |  |  |  | 4/11/65                            |  |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS   |  |  |  |  |  |                                    |  |
| K. M. ANANDIAH   |  | Union Memorial Hospital Baltimore  |  |  |  |  |  |                                    |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY                                       |  | 24D. LOCATION (City, town, or county) (State)                        |  |                                    |  |
| Burial   |  | 4-15-65  |  | Phillip B. Church Cem.   |  | PIT Co., N.C.  |  |                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |  | ADDRESS  |  |                                    |  |
| APR 12 1965  |  | Robert E. Taylor   |  | Morgan & Hyatt Furniture   |  | 916 Penna Ave  |  |                                    |  |



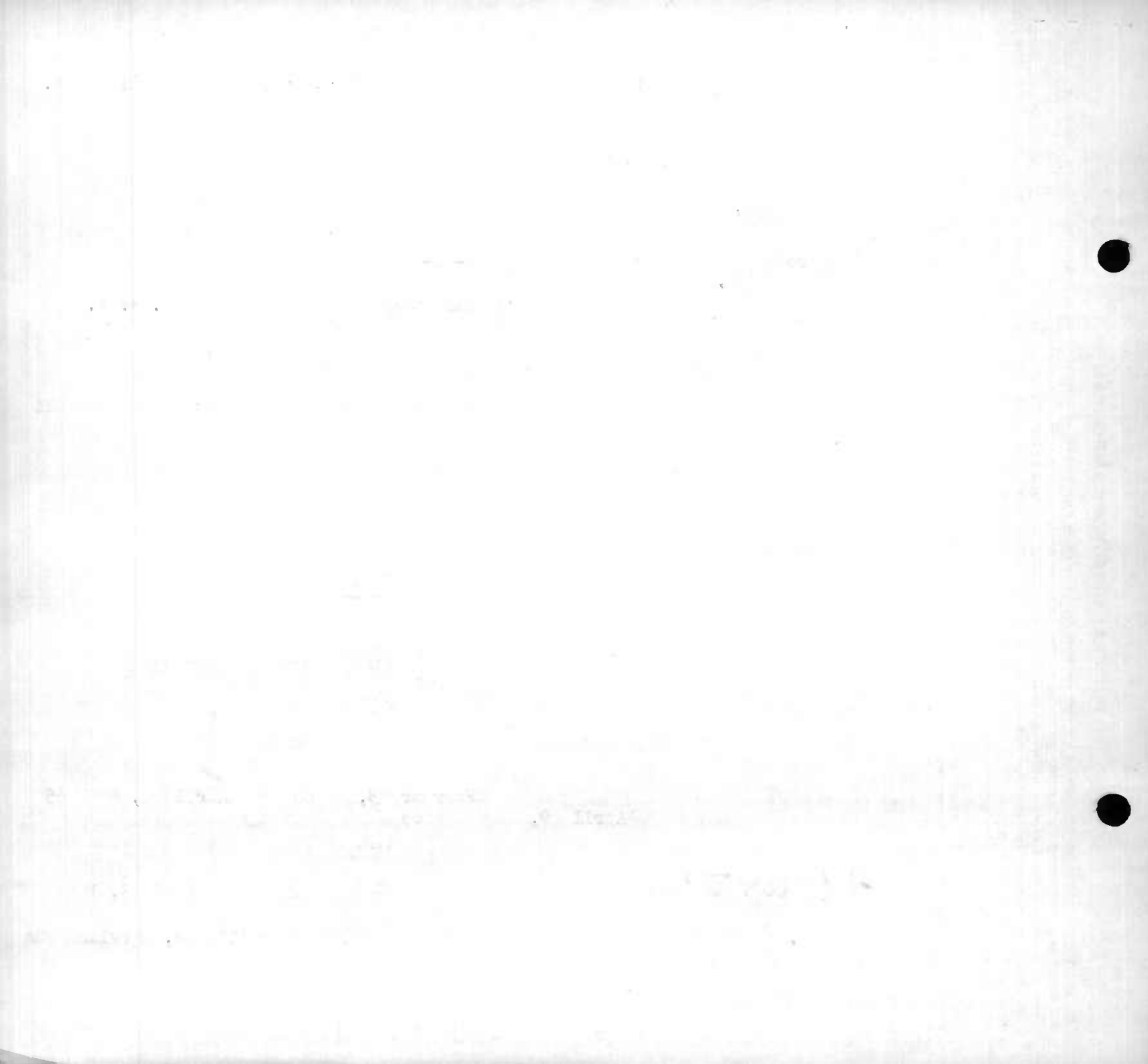


5-530

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                  |  |                               | Registered No. 65 3884   |  |
|---|------------------|--|-------------------------------|--|--|
| BIRTH NO. 65 3884   |                  | CERTIFICATE OF DEATH   |                               |  |  |
| M.E. CASE NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) Charles Smith   |                               | 2. DATE AND HOUR OF DEATH<br>April 9, 1965 11:05 A. M.                   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY 7-09            |                               |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland #21224  |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore   |                               |  |  |
|   |                  | D. STREET ADDRESS (If rural, give location)<br>1527 N Eden Street #21213   |                               |  |  |
| 5. SEX<br>Male  | 6. RACE<br>Negro | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married  | 8. DATE OF BIRTH<br>2-22-1901 | 9. AGE (In years lost birthday)<br>64                                    | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Sold Meat Canning Co  |                               | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    |  |
| 13. FATHER'S NAME<br>Charles Smith  |                  | 14. MOTHER'S MAIDEN NAME<br>Mary Mack  |                               |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO.  |                               | 17. INFORMANT ADDRESS<br>RECORDS: BCH: 4940 Eastern Avenue #21224        |  |
| 18. 163X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |                  | CAUSE OF DEATH<br>(A) Carcinoma of Lung DUE TO<br>(B) DUE TO<br>(C)  |                               | INTERVAL BETWEEN ONSET AND DEATH<br>4 Weeks                              |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |                               |  |  |
| 19A. DATE OF OPERATION<br>2   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                               | 20A. AUTOPSY? (Yes or No)<br>Yes   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                               | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from February 3, 19 65 to April 9, 19 65, that (I) (we) lost saw the deceased alive on April 9, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                     |                  |  |                               |  |  |
| 23A. SIGNATURE<br>Philip Zieve  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                               | 23B. DATE SIGNED<br>April 9, 1965  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Dr. Philip Zieve  |                  | 23D. ADDRESS<br>M.D. 4940 Eastern Avenue Baltimore, Maryland #24   |                               |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>April 13/65   |                               | 24C. NAME OF CEMETERY or CREMATORY<br>Crown Mt. Park                     |  |
| 24D. LOCATION (City, town, or county)<br>Laurel Md  |                  | 24E. (State)   |                               |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Fink   |                               | 25C. FUNERAL DIRECTOR<br>Miller & Thacker 11297 Caroline St              |  |



# FUNERAL DIRECTOR: IMPORTANT

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|   |              |  |  |  |  |
|---|--------------|--|--|--|--|
| BIRTH NO. 65 3885   |              | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3885   |  |
| M.E. CASE NO.   |              | 1. NAME OF DECEASED<br>Pauline Jones   |  | 2. DATE AND HOUR OF DEATH<br>4/8/65 16 <sup>25</sup> A.M.                |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Montebello State Hospital  |              | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>1043 Mount Street |  |  |  |
| 5. SEX<br>F   | 6. RACE<br>C | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (Specify)<br>separated  | 8. DATE OF BIRTH<br>4/23/29                  | 9. AGE (In years last birthday)<br>36                                    | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>domestic   |              | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                    | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                   |
| 13. FATHER'S NAME<br>William Grant  |              | 14. MOTHER'S MAIDEN NAME<br>Annie Mack   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |              | 16. SOCIAL SECURITY NO.  | 17. INFORMANT<br>Annie Jackson 210 Moson Ct. |  |  |
| 18. 163 X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |              | CAUSE OF DEATH<br>(A) cardiac arrest<br>DUE TO<br>(B) pulmonary congestion<br>DUE TO<br>pulmonary carcinoma  |  | INTERVAL BETWEEN ONSET AND DEATH<br>5 months                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |              |  |  |  |  |
| 19A. DATE OF OPERATION<br>2   |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br>yes   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 2/23/65 to 4/8/65, that (I) (we) last saw the deceased alive on 4/8/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |              |  |  |  |  |
| 23A. SIGNATURE<br>Robert W. Ireland   |              | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED<br>4/8/65   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Robert W. Ireland   |              | 23D. ADDRESS<br>Montebello State Hospital  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |              | 24B. DATE<br>April 12/65   |  | 24C. NAME OF CEMETERY or CREMATORY<br>Mt Auburn Cemetery                 |  |
| 24D. LOCATION (City, town, or county) (State)<br>Westport Md  |              | 25A. DATE REC'D BY HEALTH DEPT.<br>APR 12 1965   |  |  |  |
| 25B. NAME OF REGISTRAR<br>P. C. B. J. E. M. S. O. O.  |              | 25C. FUNERAL DIRECTOR<br>Milton E. Jackson 1129 N. Pauline St  |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |  |                                       | BIRTH NO. 65 3886   |  | CERTIFICATE OF DEATH   |                              | Registered No. 65 3886 |                                  |  |
|--|-------------------------|--|---------------------------------------|---|--|--|------------------------------|------------------------|----------------------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Blanton, Pauline</b>   |                         |  |                                       | 2. DATE AND HOUR OF DEATH<br><b>April 8, 1965</b>   |  | <b>5:30</b>  |                              | <b>P.M.</b>            |                                  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Joseph Hospital</b>  |                         |  |                                       | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>14-3</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 21217</b><br>D. STREET ADDRESS (If rural, give location)<br><b>508 Bleem St. 13th St.</b> |  |  |                              |                        |                                  |  |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>Negro</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Separated</b>                           | 8. DATE OF BIRTH<br><b>12-10-1919</b> |   | 9. AGE (In years last birthday)<br><b>45</b>                             | 10. Under 1 Yr. Months: Days: Hours: Min.  |                              | 11. Under 24 Hrs. Min. |                                  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY     |   | 11. BIRTHPLACE (State or foreign country)<br><b>Cumberland, Virginia</b> |  | 12. CITIZEN OF WHAT COUNTRY? |                        |                                  |  |
| 13. FATHER'S NAME<br><b>William Cory</b>   |                         |  |                                       | 14. MOTHER'S MAIDEN NAME<br><b>Mary Scott</b>   |  |  |                              |                        |                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                         |  | 16. SOCIAL SECURITY NO.               |   | 17. INFORMANT<br><b>John Blanton</b>                                     |  |                              |                        | ADDRESS<br><b>1014 August St</b> |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>260X I</b>  |                         |  |                                       | CAUSE OF DEATH<br>(A) <b>Chronic diabetic nephritis.</b><br>(B)<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH  |  |  |                              |                        |                                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |                                       |   |  |  |                              |                        |                                  |  |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                       | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b> |                              |                        |                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                       | 21C. WHERE DID INJURY OCCUR?  |  | (If in Baltimore City, give exact location)  |                              |                        |                                  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> |                                       | 21F. HOW DID INJURY OCCUR?  |  |  |                              |                        |                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>March 25, 1965</b> to <b>April 8, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 8, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                       |   |  |  |                              |                        |                                  |  |
| 23A. SIGNATURE<br><b>W B VandeGrift</b>  |                         |  |                                       | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><b>April 9, 1965</b>   |                              |                        |                                  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>William B. VandeGrift,</b>  |                         |  |                                       | 23D. ADDRESS<br>M.D. <b>1400 N. Caroline St., Baltimore, Md. 21213</b>  |  |  |                              |                        |                                  |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>Removal</b>  |                         | 24B. DATE<br><b>April 9/65</b>   |                                       | 24C. NAME OF CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Farmville Virginia</b>         |                              |                        |                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 12 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. F. ...</b>  |                                       | 25C. FUNERAL DIRECTOR<br><b>Jack T. Eshenkov 1129 N.E.</b>  |  |  |                              |                        |                                  |  |

William Gray

Mary Ann  
Parker

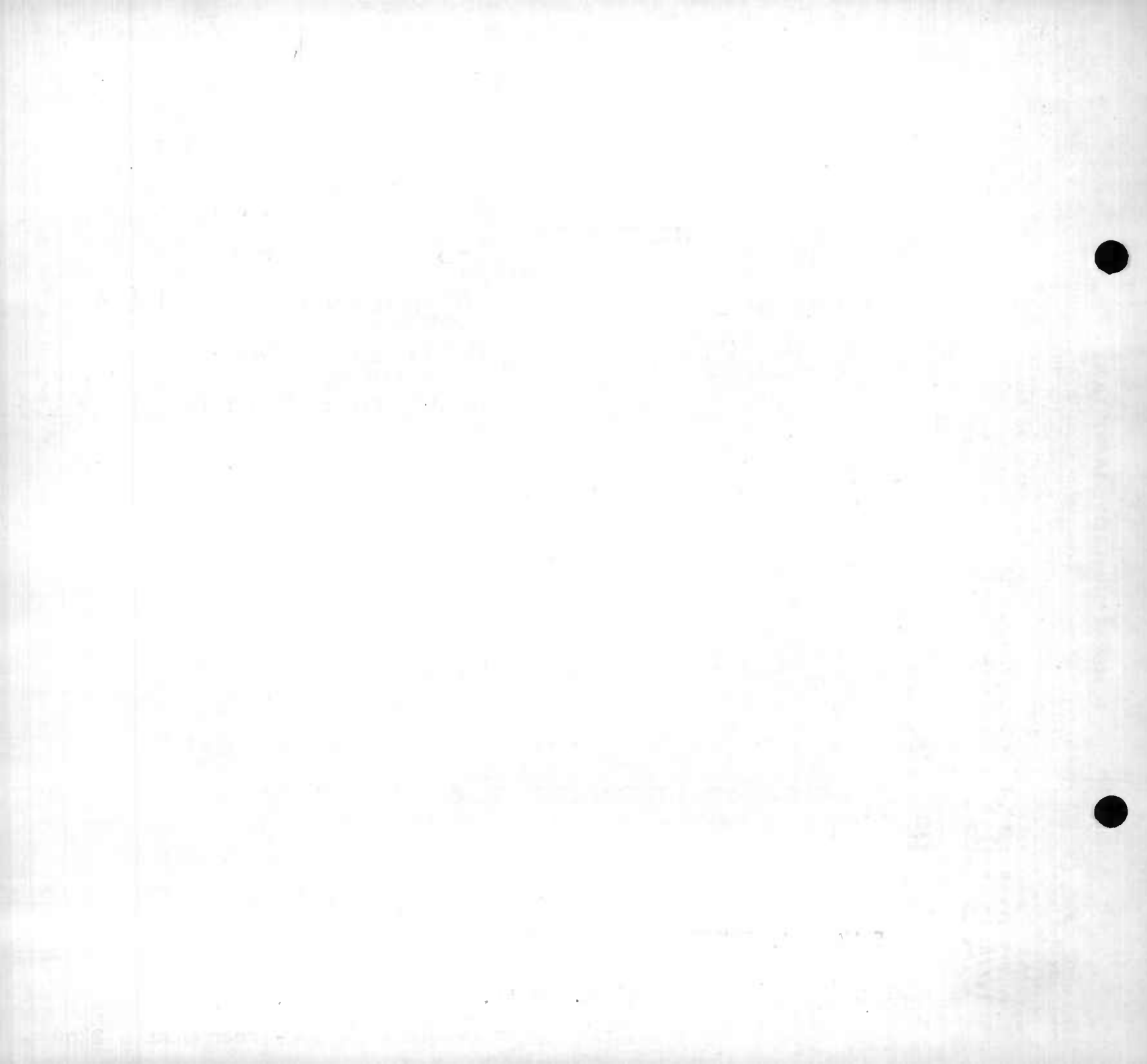
James Gray

James Gray

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                  |  |                                | Registered No. 65 3887   |  |
|--|------------------|--|--------------------------------|--|--|
| BIRTH NO. 65 3887  |                  | <b>CERTIFICATE OF DEATH</b>  |                                |  |  |
| M.E. CASE NO.  |                  | 1. NAME OF DECEASED (Type or Print) <b>MR. JOSEPH E. CLIFFORD</b>                                      |                                | 2. DATE AND HOUR OF DEATH <b>4-11-65 4 P. M.</b>                         |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |                                |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSPITAL</b>   |                  | A. STATE <b>MARYLAND</b> B. COUNTY <b>9-08</b>   |                                |  |  |
|  |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 21218</b>         |                                |  |  |
|  |                  | D. STREET ADDRESS (If rural, give location) <b>2417 GREENMOUNT AVE.</b>                                |                                |  |  |
| 5. SEX <b>M</b>  | 6. RACE <b>W</b> | 7. <del>UNMARRIED</del> <b>WEDDED, DIVORCED</b> (specify)  | 8. DATE OF BIRTH <b>1-3-97</b> | 9. AGE (In years lost birthday) <b>67</b>                                | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATCHMAN</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>                |  |
| 13. FATHER'S NAME <b>WILLIAM H. CLIFFORD</b>   |                  | 14. MOTHER'S MAIDEN NAME <b>HARRIET OWENS</b>  |                                | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>                               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.  |                                | 17. INFORMANT <b>SON</b> ADDRESS <b>4143 HAYDON COURT</b>                |  |
| 18. <b>IX</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |                  | CAUSE OF DEATH   |                                | INTERVAL BETWEEN ONSET AND DEATH   |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |                  | (A) <b>Bilateral pneumonia</b>   |                                | <b>10 days</b>   |  |
| ANTECEDENT CAUSES  |                  | (B) <b>Gastric carcinoma</b>   |                                | <b>UNKNOWN</b>   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                  | (C)  |                                |  |  |
| <b>II</b>  |                  |  |                                |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |                                |  |  |
| 19A. DATE OF OPERATION <b>15 APRIL 65</b>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>GI BLEED</b>                                       |                                | 20A. AUTOPSY? (Yes or No) <b>NO</b>                                      |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>1 APRIL 1965</b> to <b>11 APRIL 1965</b> , that (1) (we) last saw the deceased alive on <b>11 APRIL 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |                  |  |                                |  |  |
| 23A. SIGNATURE <b>Edward J. Flynn M.D.</b>   |                  |  |                                | 23B. DATE SIGNED <b>11 APRIL 65</b>                                      |  |
| 23C. PHYSICIAN'S NAME (Type) <b>EDWARD J. FLYNN</b>  |                  |  |                                | 23D. ADDRESS <b>M.D.</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 24B. DATE <b>4/14/65</b>   |                                | 24C. NAME OF CEMETERY or CREMATORY <b>Balto. Nat'l. Cem.</b>             |  |
| 24D. LOCATION (City, town, or county) <b>Balto.</b>  |                  | 24E. LOCATION (State) <b>Balto.</b>  |                                |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>APR 12 1965</b>   |                  | 25B. NAME OF REGISTRAR <b>W. E. FELD</b>   |                                | 25C. FUNERAL DIRECTOR <b>W. E. FELD &amp; SON</b>                        |  |
|  |                  |  |                                | ADDRESS <b>Greenmount &amp; 22nd</b>                                     |  |

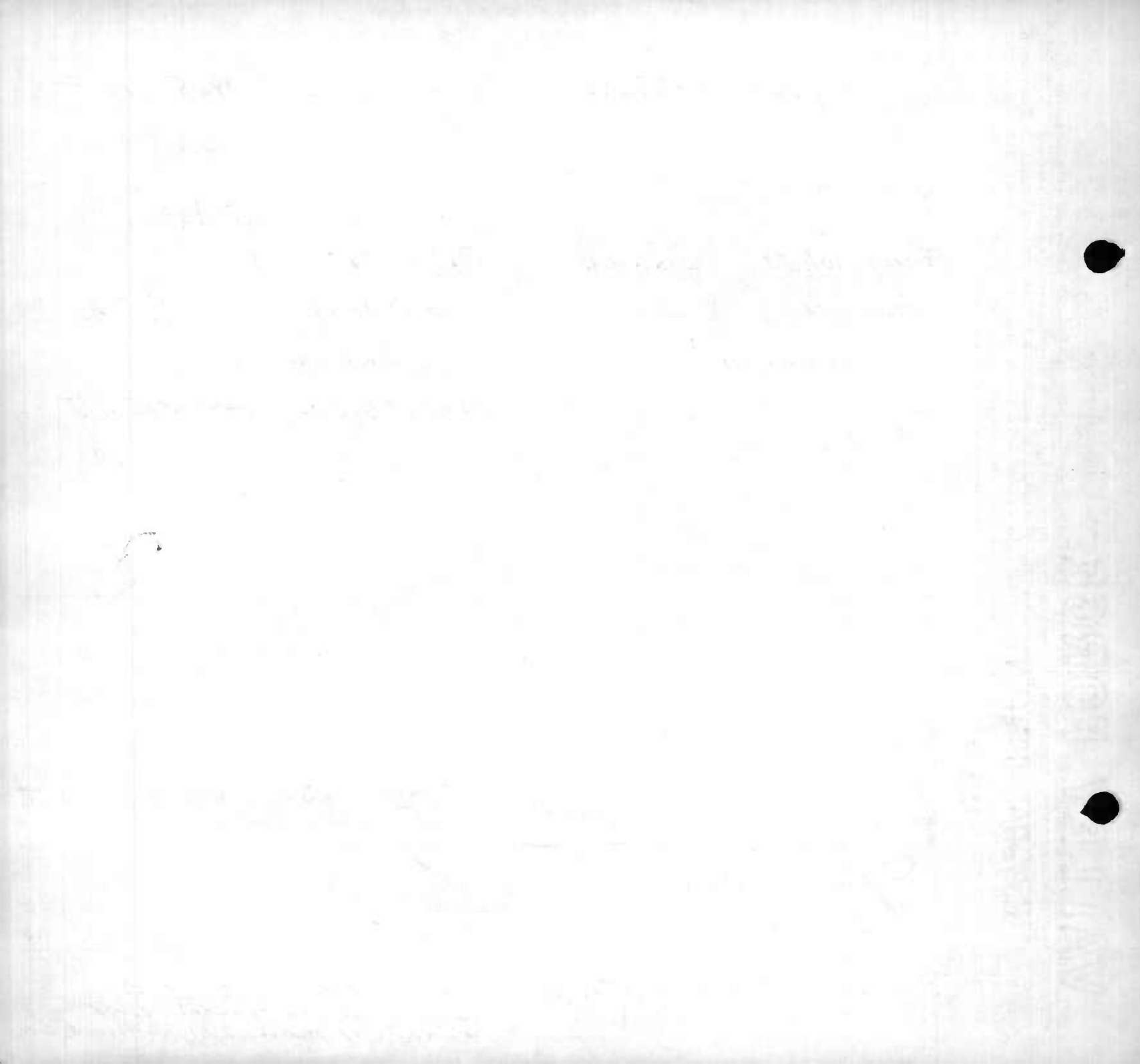




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

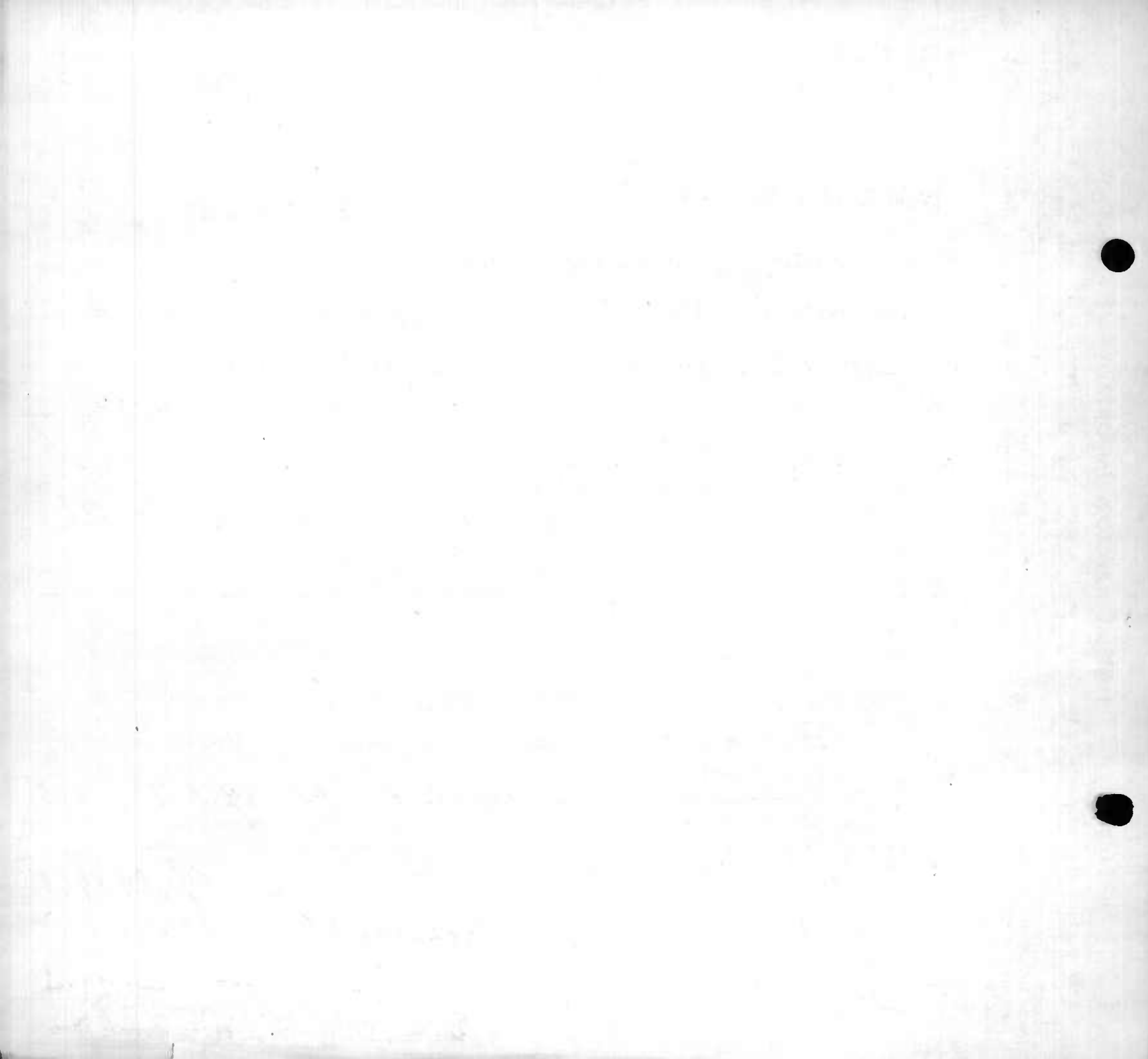
| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |  | Registered No. <u>65 3888</u>   |  |
|--|-------------------------|---|--|---|--|
| BIRTH NO. <u>65 3888</u>   |                         | <b>CERTIFICATE OF DEATH</b>   |  |   |  |
| M.E. CASE NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <u>AGNES WOLTERS</u>   |  | 2. DATE AND HOUR OF DEATH<br><u>APRIL 8, 1965 11 P.</u> M.                                  |  |
| 3. PLACE OF DEATH IN <u>BALTIMORE, MARYLAND</u>  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>27-18</u> |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>BALTIMORE</u> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>2525 W. BELVEDERE AVE.</u>  |                         | D. STREET ADDRESS (If rural, give location)<br><u>5207 BEAUFORT AVE.</u>  |  |   |  |
| 5. SEX<br><u>FEMALE</u>  | 6. RACE<br><u>white</u> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><u>widowed</u>  | 8. DATE OF BIRTH<br><u>Oct. 23, 1885</u> | 9. AGE (In years last birthday)<br><u>79</u>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Domestic</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>GERMANY</u>                                 |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                         | 13. FATHER'S NAME<br><u>Unknown</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT ADDRESS<br><u>MARGARET VIEWEG 2103 Booth St.</u>                              |  |
| 18. <u>153.81</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><u>Carcinoma of Colon</u>   |                         | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO  |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>About 2 years</u>                                    |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |   |  |   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                    |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                      |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>March - 1950</u> to <u>April 8, 1965</u> , that (I) <u>yes</u> last saw the deceased alive on <u>April 1, 1965</u> and that in (my) <u>last</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>did</u> (did not) view the body after death. |                         |   |  |   |  |
| 23A. SIGNATURE<br><u>Julius C. Gluck</u>   |                         | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>        |  | 23B. DATE SIGNED  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Julius C. Gluck</u>   |                         | 23D. ADDRESS<br><u>5356 Reisterstown Road Balto., Md</u>  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                         | 24B. DATE<br><u>4-12-65</u>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>BALTO. NATIONAL</u>                                |  |
| 24D. LOCATION<br><u>BALTIMORE, Md</u>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 12 1965</u>   |  |   |  |
| 25B. NAME OF REGISTRAR<br><u>Robert E. Fisher</u>  |                         | 25C. FUNERAL DIRECTOR<br><u>Edith A. Schwab FUNERAL HOME</u>  |  |   |  |
| 25D. ADDRESS<br><u>2101 Frederick Ave.</u>   |                         |   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. 65 3889  |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |   | Registered No. 65 3889  |  |
|--|-------------------------|---|--|---|---|---|--|
| M.E. CASE NO.  |                         |   |  | 1. NAME OF DECEASED<br>(Type or Print) <u>HANNIE ELIZABETH PEREGOY</u>                                    |   |   |  |
| 2. DATE AND HOUR OF DEATH<br><u>April 8, 1965</u> <u>1:20 P. M.</u>  |                         |   |  |   |   |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                     |   |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>522 S. BENTALOU ST.</u>   |                         |   |  | A. STATE <u>MARYLAND</u><br>B. COUNTY <u>BALTIMORE</u>  |   |   |  |
| (If not in hospital or institution, give street address or location)   |                         |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>BALTIMORE</u>               |   |   |  |
| D. STREET ADDRESS (If rural, give location)<br><u>522 S. BENTALOU ST.</u>  |                         |   |  |   |   |   |  |
| 5. SEX<br><u>FEMALE</u>  | 6. RACE<br><u>white</u> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><u>widowed</u>                                | 8. DATE OF BIRTH<br><u>Feb. 18, 1882</u> | 9. AGE (In years lost birthday)<br><u>83</u>  | If Under 1 Yr.<br>Months: Days: Hours: Min. | If Under 24 Hrs.<br>Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Domestic</u>  |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                               |  |
| 13. FATHER'S NAME<br><u>Joseph Hayward</u>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Unknown</u>  |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>NONE</u>  |  | 17. INFORMANT<br><u>MILTON S. HAYWARD</u>   |   | ADDRESS<br><u>DELTA, PA.</u>  |  |
| 18. <u>422.01</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><u>Chronic Myocarditis</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><u>Virus Bronchitis</u> |                         |   |  | (A) DUE TO<br>(B) DUE TO<br>(C)   |   | INTERVAL BETWEEN ONSET AND DEATH<br><u>2 Yrs</u><br><u>1 month</u>          |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |   |  |   |   |   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                  |   |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>April 8</u> 19 <u>63</u> to <u>April 8</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |  |   |   |   |  |
| 23A. SIGNATURE<br><u>L. A. Lally MD</u> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                         |   |  | 23B. DATE SIGNED<br><u>April 9 1965</u>   |   |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>L A LALLY</u> M.D.  |                         |   |  | 23D. ADDRESS<br><u>ROLLING Rd + FREDERICK Rd</u>  |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                         | 24B. DATE<br><u>4-12-65</u>   |  | 24C. NAME of CEMETERY or CREMATORY<br><u>London PARK</u>  |   | 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE, MARYLAND</u> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 12 1965</u>  |                         | 25B. NAME OF REGISTRAR<br><u>Robert E. [unclear]</u>  |  | 25C. FUNERAL DIRECTOR<br><u>650-43 Schwab Funeral Home</u><br><u>1400 N. [unclear] 2101 [unclear] Ave</u> |   |   |  |



# FUNERAL DIRECTOR: IMPORTANT

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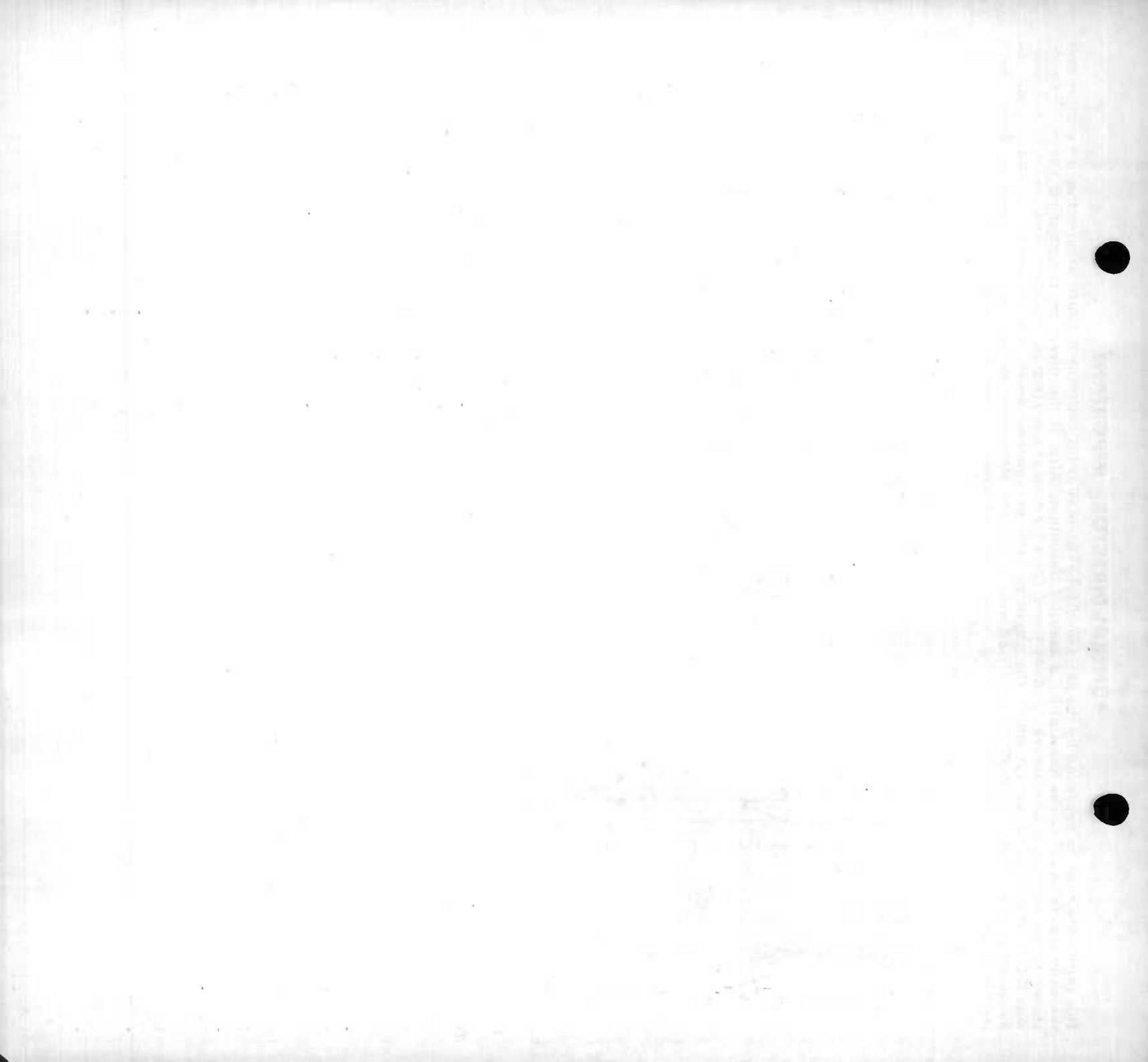
| BIRTH NO. 65 3890  |                     |   |   | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3890  |  |
|--|---------------------|---|---|--|---|---|--|
| M.E. CASE NO. 65 3890  |                     |   |   |  |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Catherine Green</i>  |                     |   |   | 2. DATE AND HOUR OF DEATH<br><i>4-6-65 11 40 A.M.</i>  |   |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |   |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>UNIVERSITY HOSPITAL</i>   |                     |   |   | A. STATE <i>Md.</i> B. COUNTY <i>Baltimore</i>   |   |   |  |
|  |                     |   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>  |   |   |  |
|  |                     |   |   | D. STREET ADDRESS (If rural, give location)<br><i>887 W Fayette St. #1</i>   |   |   |  |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>N</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)  | 8. DATE OF BIRTH<br><i>2-19-22</i>            | 9. AGE (In years lost birthday)<br><i>43</i>   | If Under 1 Yr.<br>Months                                  | If Under 24 Hrs.<br>Days  | If Under 24 Hrs.<br>Hours                  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Domestic</i>   |                     |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>-</i> |  | 11. BIRTHPLACE (State or foreign country)<br><i>N. C.</i> |   | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |
| 13. FATHER'S NAME<br><i>John Strichling</i>  |                     |   | 14. MOTHER'S MAIDEN NAME<br><i>Alphie</i>     |  |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                     |   | 16. SOCIAL SECURITY NO.<br><i>-</i>           |  | 17. INFORMANT<br><i>-</i>                                 |   |  |
| 18. <i>600.01</i>  |                     |   | CAUSE OF DEATH                                |  |   |   | INTERVAL BETWEEN ONSET AND DEATH           |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |                     |   | (A) <i>Uremia</i><br>DUE TO                   |  |   |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |   | (B) <i>Chronic renal disease</i><br>DUE TO    |  |   |   |  |
|  |                     |   | (C) <i>Probably chronic pyelonephritis</i>    |  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |   | <i>G.I. bleeding</i>                          |  |   |   |  |
| 19A. DATE OF OPERATION<br><i>2</i>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><i>Yes</i>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><i>No</i> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |   |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-5</i> 19 <i>65</i> to <i>4-6</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4-6</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |   |  |   |   |  |
| 23A. SIGNATURE<br><i>Michael S. Hayes</i>  |                     |   |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED<br><i>4-6-65</i>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>M</i>   |                     |   |   | 23D. ADDRESS<br>M.D. <i>LOMBARD &amp; GREENE STS.</i>  |   |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                     | 24B. DATE<br><i>4/12/65</i>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt. Auburn Cem. Baltimore, Md.</i>  |   | 24D. LOCATION<br>(City, town, or county) (State)<br><i>Md.</i>                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 12 1965</i>  |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. Bailey</i>   |   | 25C. FUNERAL DIRECTOR<br><i>Williams Funeral Home</i>  |   | ADDRESS<br><i>918 Broadway St.</i>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |   |  |  | Registered No. <span style="font-size: 1.2em;">65 3891</span>  |   |
|--|---|--|--|--|---|
| BIRTH NO. <span style="font-size: 1.2em;">65 3891</span>   |   | <b>CERTIFICATE OF DEATH</b>  |  |  |   |
| M.E. CASE NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.1em;">Adda Irene Ford</span>  |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.1em;">April 10, 1965</span>                     |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <span style="font-size: 1.1em;">Md.</span><br>B. COUNTY <span style="font-size: 1.1em;">26-02</span> |  | M.   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="font-size: 1.1em;">5105 Belair Road</span>  |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.1em;">Balto.</span>   |  | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.1em;">5105 Belair Road</span> |   |
| 5. SEX<br><span style="font-size: 1.1em;">Female</span>  | 6. RACE<br><span style="font-size: 1.1em;">White</span> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.1em;">Widowed</span>   | 8. DATE OF BIRTH<br><span style="font-size: 1.1em;">June 24, 1889</span> | 9. AGE (In years last birthday)<br><span style="font-size: 1.1em;">75</span>                           | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.1em;">Housewife</span>  |   | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.1em;">Ohio</span>               |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.1em;">U.S.A.</span>  |   | 13. FATHER'S NAME<br><span style="font-size: 1.1em;">William Hunter</span>   |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.1em;">Alice Knox</span>                          |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |   | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><span style="font-size: 1.1em;">Mrs. Florence M. Green, 4139 Eierman Ave</span>       |   |
| 18. <span style="font-size: 1.1em;">4-20-1 I</span>  |   | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH   |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |   | (A) <span style="font-size: 1.1em;">CORONARY OCCLUSION</span><br>DUE TO  |  | <span style="font-size: 1.1em;">ACUTE</span>   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   | (B)<br>DUE TO  |  |  |   |
|  |   | (C) <span style="font-size: 1.1em;">CORONARY INSUFFICIENCY</span>  |  | <span style="font-size: 1.1em;">2 YEARS</span>   |   |
| II   |   | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  | <span style="font-size: 1.1em;">ARTERIO SCLEROSIS, GENERALIZED</span>                                  |   |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.1em;">0</span>   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                               |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |   | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <span style="font-size: 1.1em;">MARCH</span> 19 <span style="font-size: 1.1em;">48</span> to <span style="font-size: 1.1em;">APRIL 8</span> , 19 <span style="font-size: 1.1em;">65</span> , that (I) <del>we</del> last saw the deceased alive on <span style="font-size: 1.1em;">APRIL 8</span> , 19 <span style="font-size: 1.1em;">65</span> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <del>(did)</del> view the body after death. |   |  |  |  |   |
| 23A. SIGNATURE<br><span style="font-size: 1.1em;">Gilbert E. Rudman</span>   |   | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Stoll Phys. <input type="checkbox"/>   |  | 23B. DATE SIGNED<br><span style="font-size: 1.1em;">4/12/65</span>                                     |   |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.1em;">GILBERT E. RUDMAN</span>   |   | 23D. ADDRESS<br><span style="font-size: 1.1em;">2517 W. Balto. St.</span>  |  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.1em;">burial</span>  |   | 24B. DATE<br><span style="font-size: 1.1em;">4-13-65</span>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><span style="font-size: 1.1em;">Loudon Park Cemetery</span>      |   |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.1em;">Baltimore, Md.</span>   |   | 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |   |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.1em;">Leonard J. Ruck, Inc., Balto., Md.</span>   |   | ADDRESS  |  |  |   |
| APR 13 1965 <span style="font-size: 1.1em;">Gilbert E. Rudman</span>   |   |  |  |  |   |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |  |                                    |  |  |
|--|-------------------------|--|------------------------------------|--|--|
| BIRTH NO. 65 3892  |                         | BALTIMORE CITY HEALTH DEPARTMENT   |                                    | Registered No. 65 3892   |  |
| M.E. CASE NO.  |                         | CERTIFICATE OF DEATH   |                                    | 7:20 am  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Green George Henry</u>   |                         | 2. DATE AND HOUR OF DEATH<br><u>4-12-65</u>  |                                    | <u>7:20 am</u>   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  |                                    | M. STATE   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Union Memorial Hospital</u>   |                         | A. STATE <u>Maryland</u>   |                                    | B. COUNTY <u>2705</u>  |  |
| (If not in hospital or institution, give street address or location)   |                         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>Baltimore - 6</u>                                      |                                    | D. STREET ADDRESS (If rural, give location)<br><u>6645 Walther Ave.</u>  |  |
| 5. SEX<br><u>Male</u>  | 6. RACE<br><u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><u>married</u>   | 8. DATE OF BIRTH<br><u>8-19-00</u> | 9. AGE (In years last birthday)<br><u>64</u>                             | If Under 1 Yr. Months Days / If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Pinkerton Det. Agency</u>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>Maryland</u>             |  |
| 13. FATHER'S NAME<br><u>George J. Green</u>  |                         | 14. MOTHER'S MAIDEN NAME<br><u>Rebecca L. Wiley</u>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>                            |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>yes WW I</u>  |                         | 16. SOCIAL SECURITY NO.<br><u>216108497</u>  |                                    | 17. INFORMANT<br><u>Ella June Green</u>                                  |  |
| 18. <u>420.1 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                           |                         | CAUSE OF DEATH<br>(A) <u>Acute Myocardial Infarction</u><br>DUE TO<br>(B) _____<br>DUE TO<br>(C) _____                               |                                    | INTERVAL BETWEEN ONSET AND DEATH   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |                                    |  |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No)<br><u>No</u>                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>                 |                                    | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>APRIL 11</u> 19 <u>65</u> to <u>APRIL 12</u> 19 <u>65</u> , that (I) (we) last saw the deceased alive on <u>APRIL 11</u> <u>11 pm</u> 19 <u>65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                    |  |  |
| 23A. SIGNATURE<br><u>Chi Tsung Su</u>  |                         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                    | 23B. DATE SIGNED<br><u>APRIL 12: 1965</u>                                |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>CHI TSUNG SU</u>  |                         | 23D. ADDRESS<br><u>UNION MEMORIAL HOSPITAL</u>   |                                    |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>burial</u>  |                         | 24B. DATE<br><u>4-15-65</u>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><u>Meadowridge Cemetery</u>        |  |
| 24D. LOCATION<br><u>Elkridge, Md.</u>  |                         | 24E. DATE REC'D BY HEALTH DEPT.<br><u>APR 13 1965</u>  |                                    |  |  |
| 25A. NAME OF REGISTRAR<br><u>Robert E. ...</u>   |                         | 25B. NAME OF REGISTRAR   |                                    | 25C. FUNERAL DIRECTOR<br><u>Leonard J. Ruck Inc Baltimore, Md.</u>       |  |

DATE: 7/21/67

12 5 84

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

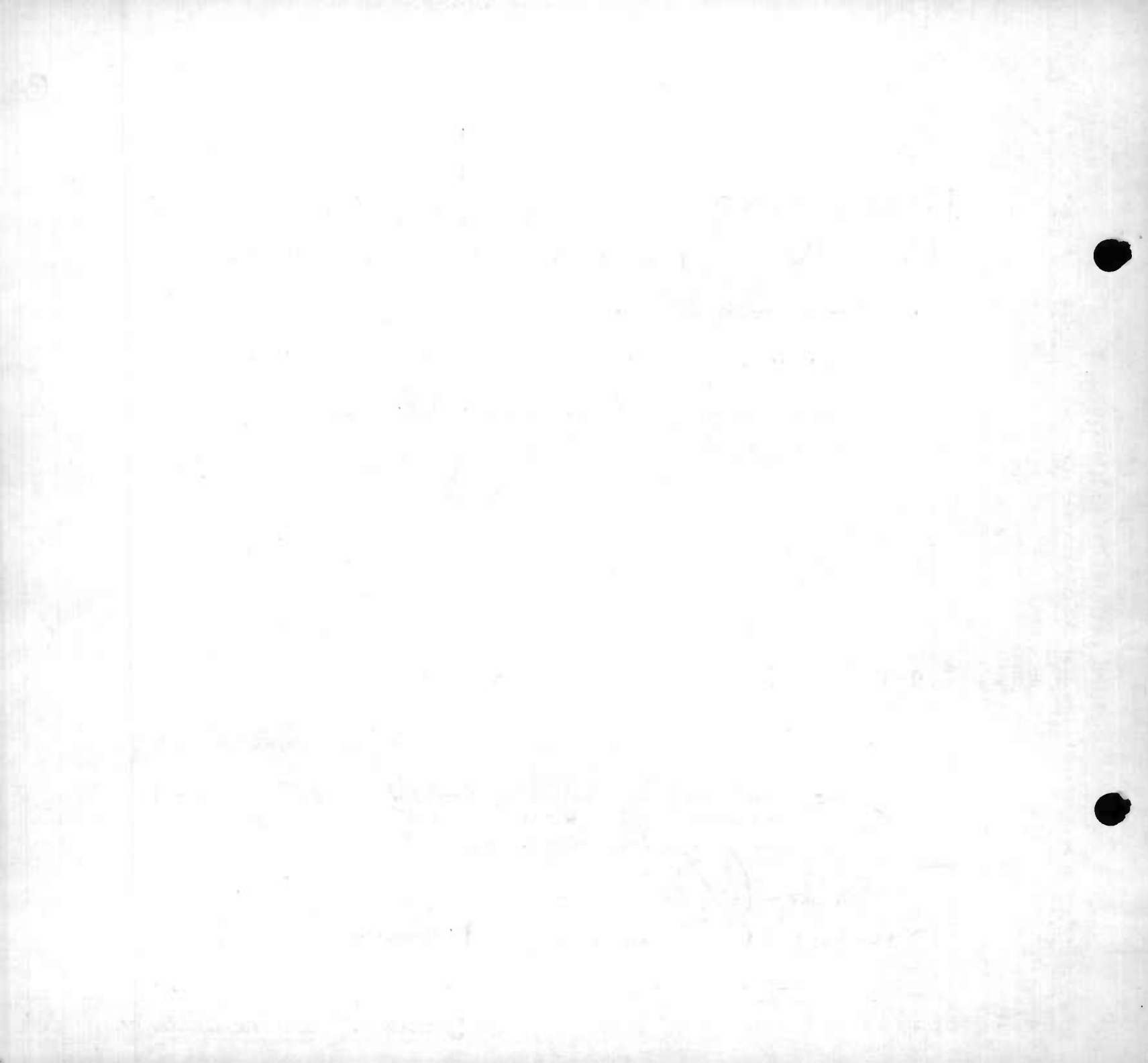
| BALTIMORE CITY HEALTH DEPARTMENT  |                   |   |                          | Registered No. 65 3893   |   |
|---|-------------------|---|--------------------------|--|---|
| BIRTH NO. 65 3893   |                   | CERTIFICATE OF DEATH  |                          |  |   |
| M.E. CASE NO.   |                   | 1. NAME OF DECEASED (Type or Print) VAUGHN Edward Legar   |                          | 2. DATE AND HOUR OF DEATH April 11, 1965 12:45 P.M.                      |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                          |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |                   | A. STATE MARYLAND   |                          | B. COUNTY  |   |
| Union Memorial Hospital   |                   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)   |                          | Baltimore 27-01  |   |
| Baltimore, Maryland   |                   | D. STREET ADDRESS (If rural, give location)   |                          | 3123 WEAVER AVENUE   |   |
| 5. SEX male   | 6. RACE CAUCASIAN | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) MARRIED   | 8. DATE OF BIRTH 11/9/06 | 9. AGE (In years last birthday) 58                                       | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired   |                   | 10B. KIND OF BUSINESS OR INDUSTRY Accountant  |                          | 11. BIRTHPLACE (State or foreign country) Baltimore Maryland             |   |
| 12. CITIZEN OF WHAT COUNTRY? United States  |                   | 13. FATHER'S NAME VAUGHN O. LEGAR   |                          | 14. MOTHER'S MAIDEN NAME Lilly M. Jacobs                                 |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes  |                   | 16. SOCIAL SECURITY NO.   |                          | 17. INFORMANT Mrs. Mildred M. Legar                                      |   |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |                   | CAUSE OF DEATH  |                          | INTERVAL BETWEEN ONSET AND DEATH 2-3 days.                               |   |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |                   | (A) DUE TO Recent myocardial infarction   |                          |  |   |
| ANTECEDENT CAUSES   |                   | (B) DUE TO Thrombosis of Rt coronary artery   |                          |  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                   | (C) old extensive myocardial infarct  |                          |  |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                   | Generalized severe arteriosclerosis   |                          | occlusion of rt renal artery & secondary atrophy of kidney               |   |
| 19A. DATE OF OPERATION 2  |                   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          | 20A. AUTOPSY? (Yes or No) YES  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                          |                          | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from April 6, 1965 to April 11, 1965, that (I) (we) last saw the deceased alive on April 11, 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                   |   |                          |  |   |
| 23A. SIGNATURE David Merritt Mac Millan M.D.  |                   | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                          | 23B. DATE SIGNED 4/11/65   |   |
| 23C. PHYSICIAN'S NAME (Type) DAVID MERRITT MAC MILLAN M.D.  |                   | 23D. ADDRESS Union Memorial Hospital  |                          |  |   |
| 24A. BURIAL CREMATION REMOVAL (Specify) Burial  |                   | 24B. DATE 4/14/65   |                          | 24C. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery                     |   |
| 24D. LOCATION Baltimore, Maryland   |                   |   |                          |  |   |
| 25A. DATE REC'D BY HEALTH DEPT. APR 13 1965   |                   | 25B. NAME OF REGISTRAR  |                          | 25C. FUNERAL DIRECTOR ADDRESS Leonard O. Buck Inc 5305 Harford Road #14  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

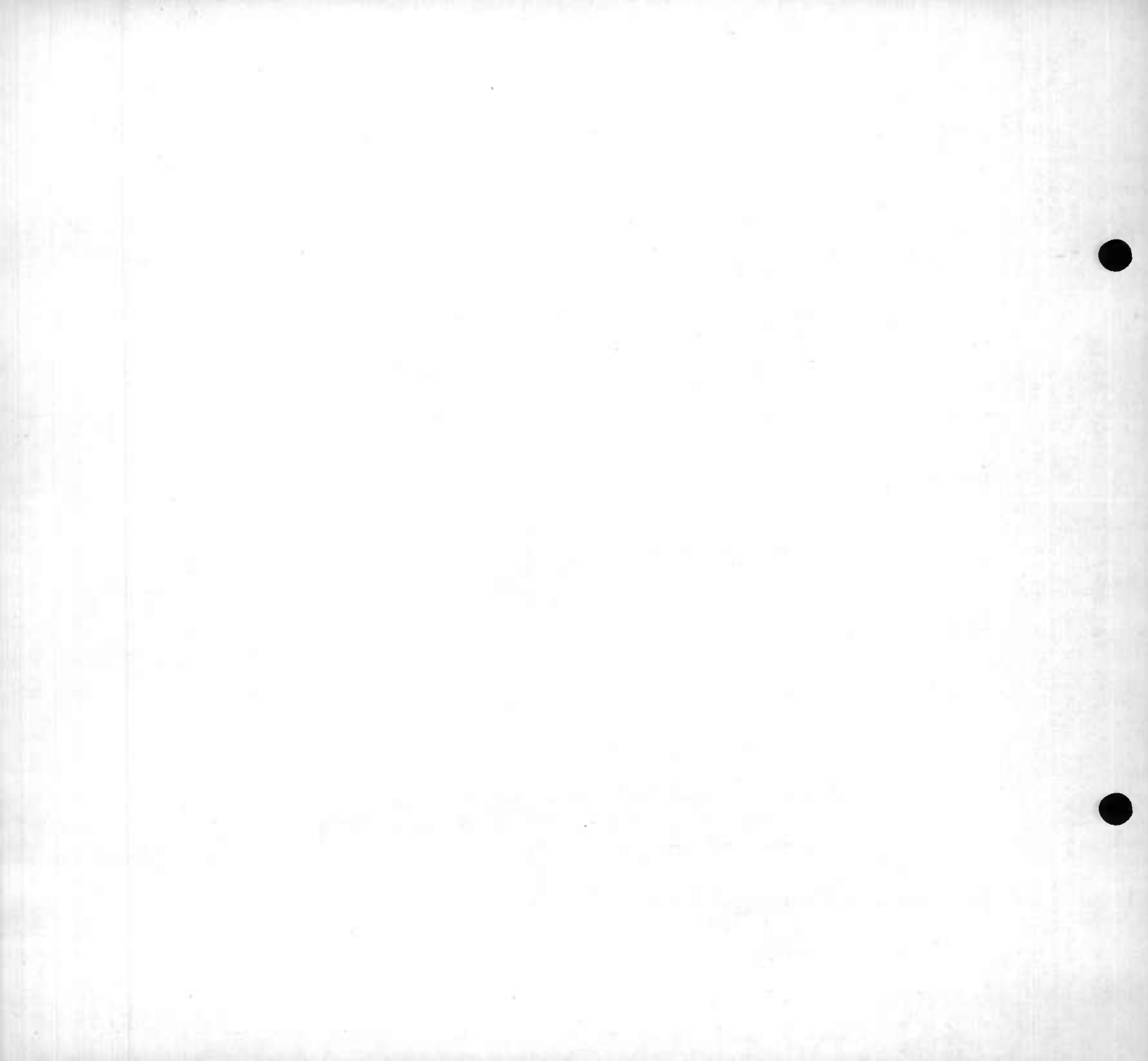
| Baltimore City Health Department  |                     |  |                                   | Registered No.   |  |
|---|---------------------|--|-----------------------------------|--|--|
| BIRTH NO.   |                     | 65 3894  |                                   | 65 3894  |  |
| M.E. CASE NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>ALFRED John ENGEL</b>  |                                   | 2. DATE AND HOUR OF DEATH<br><b>4-11-65 1:45 PM</b>                      |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                                   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><b>Mercy Hosp.</b>  |                     | A. STATE <b>MARYLAND</b> B. COUNTY <b>27-05</b>  |                                   |  |  |
|   |                     | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b>  |                                   |  |  |
|   |                     | D. STREET ADDRESS (If rural, give location)<br><b>3047 PINWOOD AVE.</b>  |                                   |  |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>   | 8. DATE OF BIRTH<br><b>9-6-92</b> | 9. AGE (In years last birthday)<br><b>72</b>                             | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Ret. Superintendent Box Co.</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY  |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                     | 13. FATHER'S NAME<br><b>William J. H. Engel</b>  |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Caroline Buchwald</b>                     |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                     | 16. SOCIAL SECURITY NO.<br><b>216099097</b>  |                                   | 17. INFORMANT<br><b>Jean V. Engel</b> ADDRESS<br><b>same</b>             |  |
| 18. <b>181.0 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>CA of URINARY BLADDER</b>  |                     | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO   |                                   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                     |  |                                   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |  |                                   |  |  |
| 19A. DATE OF OPERATION<br><b>19-1-65</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>segmental bladder Resect.</b>   |                                   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                                   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (this hospital) attended the deceased from <b>3-24-1965</b> to <b>4-11-1965</b> , that (I) <b>we</b> last saw the deceased alive on <b>4-11-1965</b> and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above. (I) <b>we</b> (did) <b>did not</b> view the body after death. |                     |  |                                   |  |  |
| 23A. SIGNATURE<br><b>Salvatore R. Donohue</b>   |                     | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                   | 23B. DATE SIGNED<br><b>4-11-65</b>                                       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SALVATORE R. DONOHUE</b>   |                     | 23D. ADDRESS<br><b>MERCY HOSP.</b>   |                                   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                     | 24B. DATE<br><b>4-15-65</b>  |                                   | 24C. NAME of CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b>        |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |                     |  |                                   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                     | 25B. NAME OF REGISTRAR<br><b>Leonard J. Ruck</b>   |                                   | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc Baltimore, Md.</b>       |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |  |  |
|---|------------------|--|--|
| BALTIMORE CITY, HEALTH DEPARTMENT   |                  | Registered No. <b>65 3895</b>  |  |
| BIRTH NO. <b>65 3895</b>  |                  | <b>CERTIFICATE OF DEATH</b>  |  |
| M.E. CASE NO.   |                  | 2. DATE AND HOUR OF DEATH <b>4-10-65 1 330 A M.</b>  |  |
| 1. NAME OF DECEASED (Type or Print) <b>CAYCE ANNIE C.</b>   |                  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>UNION MEMORIAL HOSP</b>  |                  | A. STATE <b>BALTIMORE</b> B. COUNTY <b>BALTIMORE</b>   |  |
|   |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 9-06</b>          |  |
|   |                  | D. STREET ADDRESS (If rural, give location) <b>2835 HILLEN RD.</b>                                     |  |
| 5. SEX <b>♀</b>   | 6. RACE <b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>WIDOWED</b>                                  | 8. DATE OF BIRTH <b>11-22-99</b>                                 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 9. AGE (In years last birthday) <b>65</b>                        |
| 11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>   |                  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |
| 13. FATHER'S NAME <b>JOHN COLE YOUNG</b>  |                  | 14. MOTHER'S MAIDEN NAME <b>LILLIAN WHITELOCK</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                  | 16. SOCIAL SECURITY NO. <b>217220610</b>   | 17. INFORMANT <b>MARY REBUCK</b> ADDRESS <b>8664 ROCKFORD RD</b> |
| 18. <b>420.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) <b>MYOCARDIAL INFARCTION NONE</b><br>DUE TO<br>(B) DUE TO<br>(C)                 |  |
| INTERVAL BETWEEN ONSET AND DEATH  |                  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                  |  |  |
| 19A. DATE OF OPERATION <b>0</b>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)   |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |
| 21F. HOW DID INJURY OCCUR?  |                  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-10-65</b> 19 to <b>4-10-65</b> 19, that (I) (we) last saw the deceased alive on <b>4-10-65</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                         |                  |  |  |
| 23A. SIGNATURE <b>James L. Canady</b> M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                  | 23B. DATE SIGNED <b>4-10-65</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)  |                  | 23D. ADDRESS <b>UNION MEMORIAL HOSP</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>  |                  | 24B. DATE <b>4-14-65</b>   |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>Moreland Mem. Park</b>  |                  | 24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>                                    |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>APR 13 1965</b>  |                  | 25B. NAME OF REGISTRAR <b>Reuben E. Taylor</b>   |  |
| 25C. FUNERAL DIRECTOR <b>Georgiadis Inc</b>   |                  | ADDRESS <b>Baltimore, Md.</b>  |  |

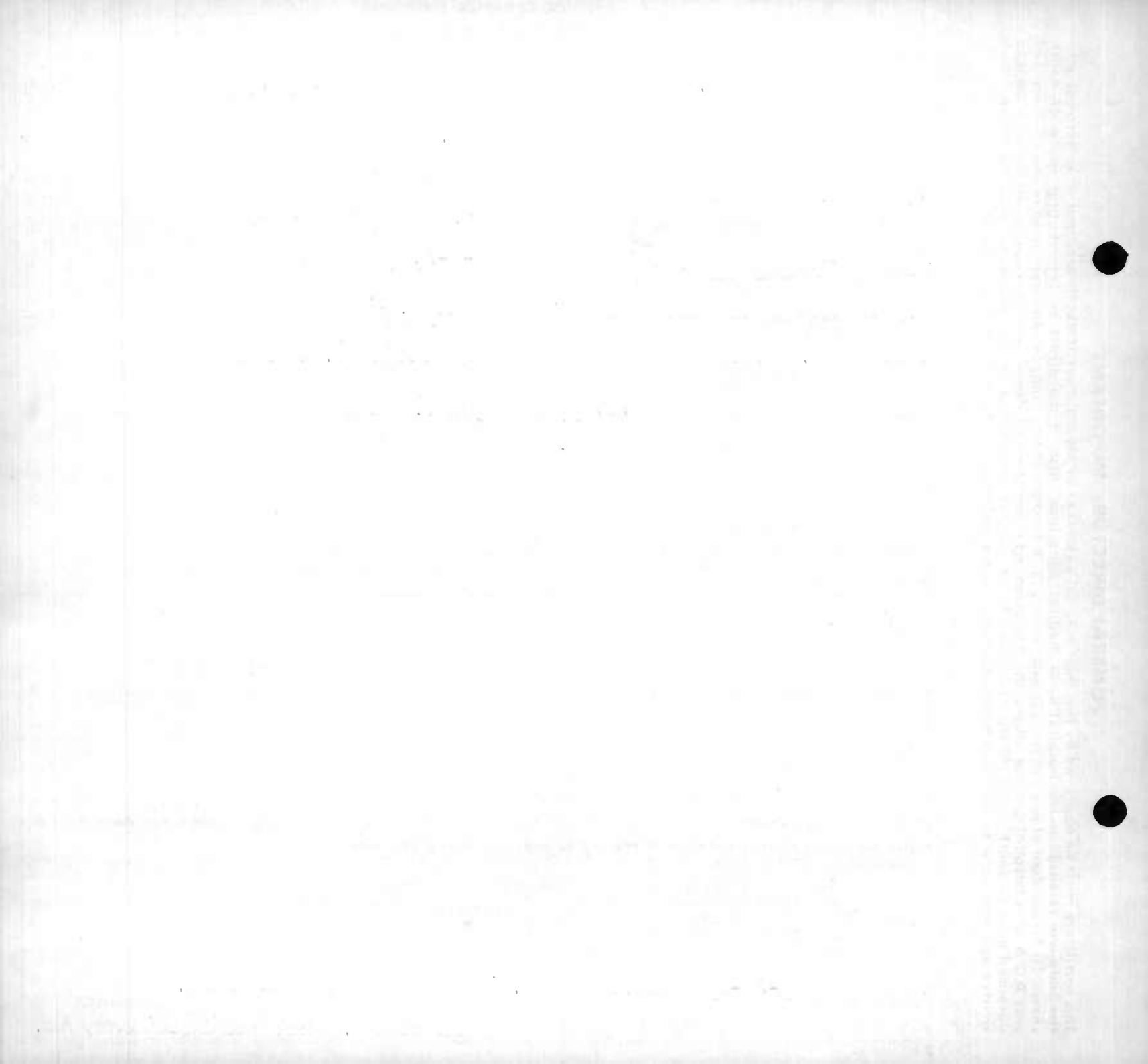




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

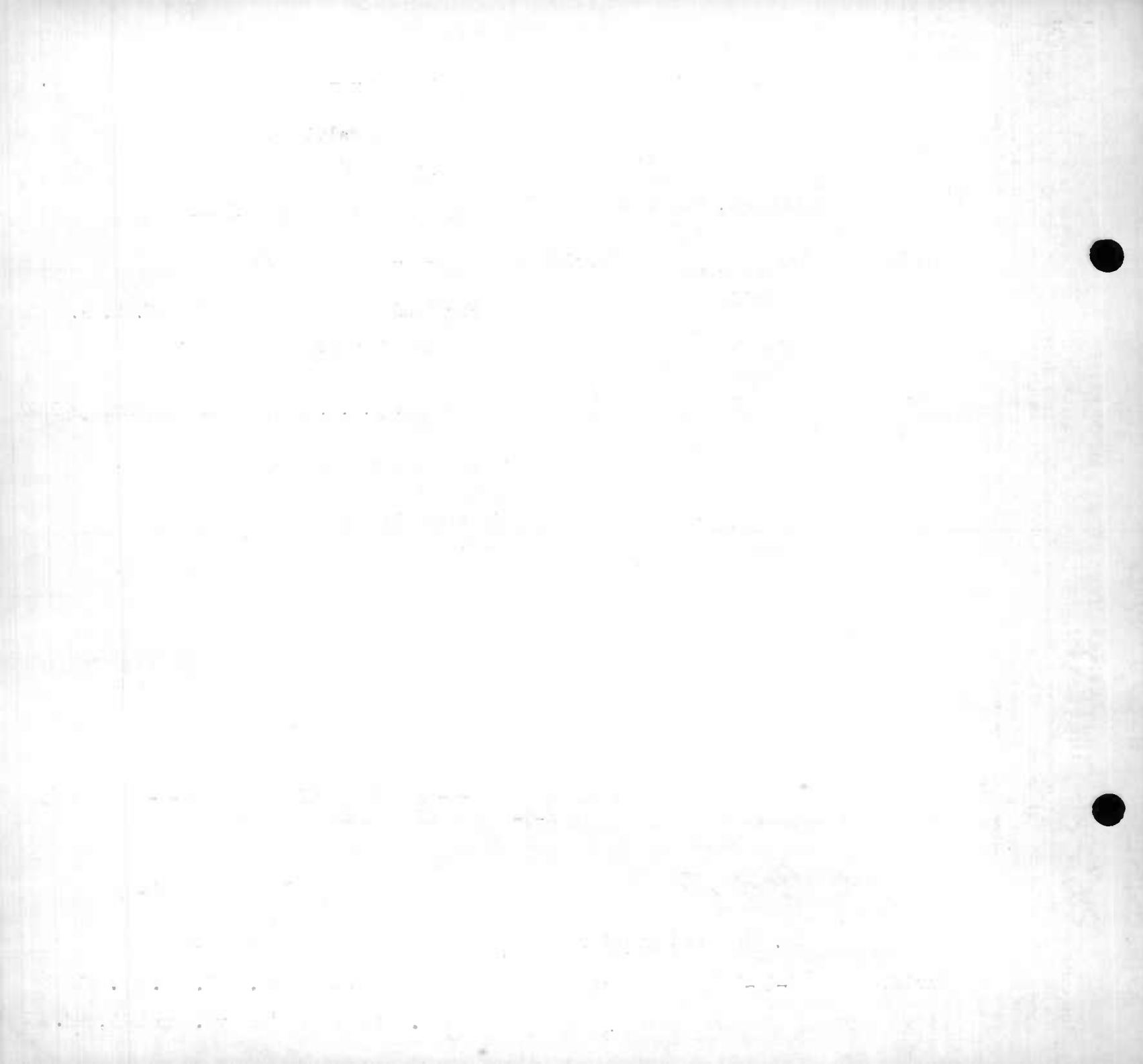
| BALTIMORE CITY HEALTH DEPARTMENT   |   |   |  | CERTIFICATE OF DEATH   |  | Registered No. <span style="font-size: 1.2em;">65 3896</span>  |  |
|--|---|---|--|--|--|--|--|
| BIRTH NO. <span style="font-size: 1.2em;">65 3896</span>   |   | M.E. CASE NO. <span style="font-size: 1.2em;">65 3896</span>  |  | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">Leo P. Burns</span>   |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">April 10, 1965 4:05 P. M.</span>                                      |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><span style="font-size: 1.2em;">1908 Wadsworth Way</span>   |   |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.2em;">27-38</span><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.2em;">Baltimore</span><br>D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.2em;">1908 Wadsworth Way</span> |  |  |  |
| 5. SEX<br><span style="font-size: 1.2em;">male</span>  | 6. RACE<br><span style="font-size: 1.2em;">white</span> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.2em;">married</span>  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">2-7-1904</span>                    | 9. AGE (in years lost birthday)<br><span style="font-size: 1.2em;">61</span>   | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Senior Inspector</span>   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">Baltimore City</span>                |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Maryland</span>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">USA</span>   |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Patrick J. Burns</span>   |   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Catherine T. Toulon</span> |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">no</span>  |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">218185543</span>                               |  | 17. INFORMANT<br><span style="font-size: 1.2em;">Eva T. Burns</span>   |  | ADDRESS<br><span style="font-size: 1.2em;">same</span>   |  |
| 18. <span style="font-size: 1.2em;">163 X I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   |   |  | CAUSE OF DEATH<br>(A) <span style="font-size: 1.2em;">Cerebral mita-tan</span><br>DUE TO<br>(B) <span style="font-size: 1.2em;">Carcinoma of the lung</span><br>DUE TO<br>(C)  |  | INTERVAL BETWEEN ONSET AND DEATH<br><span style="font-size: 1.2em;">1 yr</span><br><span style="font-size: 1.2em;">1 yr - 4</span> |  |
|  |   |   |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">0 9-64</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><span style="font-size: 1.2em;">Ca-lung</span>        |  | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">no</span>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Approx.)<br>(Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">19 10</span> to <span style="font-size: 1.2em;">4-10</span> 1965, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">4-10</span> 19 <span style="font-size: 1.2em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. |   |   |  |  |  |  |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">J. DUBA MOORE</span>   |   |   |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">4-12-65</span>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">J. DUBA MOORE</span>   |   |   |  | 23D. ADDRESS<br><span style="font-size: 1.2em;">3105 Belair Rd - 21213</span>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">burial</span>  |   | 24B. DATE<br><span style="font-size: 1.2em;">4-14-65</span>   |  | 24C. NAME of CEMETERY or CREMATORY<br><span style="font-size: 1.2em;">Moreland Mem. Park</span>  |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Baltimore, Md.</span>                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">APR 13 1965</span>  |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. ...</span>                            |  | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Leonard J. Ruck Inc</span>  |  | ADDRESS<br><span style="font-size: 1.2em;">Baltimore, Md.</span>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |   |  |  |
|--|-------------------------|---|---|--|--|
| BIRTH NO. 65 3897  |                         | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>   |   | Registered No. 65 3897   |  |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print) <b>Bertha Shimek</b>   |                         |   | 2. DATE AND HOUR OF DEATH<br><b>4-9-65</b>   <b>2:25 P. M.</b>  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Baltimore City Hospitals<br/>4940 Eastern Avenue<br/>Baltimore, Maryland #21224</b>  |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland, Baltimore</b><br>B. COUNTY <b>Balto</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Rural Dundalk 5300</b><br>D. STREET ADDRESS (If rural, give location)<br><b>7208 Kimmel Avenue #21222</b> |  |  |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>                                | 8. DATE OF BIRTH<br><b>1-18-1916</b>  | 9. AGE (In years last birthday)<br><b>49</b>                             | If Under 1 Yr. Months Days   If Under 24 Hrs. Hours Min.   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |
| 13. FATHER'S NAME<br><b>Louis Ahl</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Lena Eiermann</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>No</b>  | 17. INFORMANT ADDRESS<br><b>RECORDS: B.C.H. 4940 Eastern Avenue #21224</b>  |  |  |
| 18. <b>420.1 I</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) Possible Myocardial Infarction<br/>DUE TO Arrhythmia</b><br><b>(B) Arteriosclerotic Cardio Vascular<br/>DUE TO Disease</b><br><b>(C)</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |   |   |  |  |
| INTERVAL BETWEEN ONSET AND DEATH<br><b>?</b>   |                         |   |   |  |  |
| MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |   |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-9-65</b> to <b>4-9-1965</b> , that (I) (we) last saw the deceased alive on <b>4-9-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |   |  |  |
| 23A. SIGNATURE<br><b>Dr. Charles Carpenter</b>   |                         |   | 23B. DATE SIGNED<br><b>4-9-65</b>   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Charles Carpenter</b>   |                         |   | 23D. ADDRESS<br><b>4940 Eastern Avenue #21224</b>   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4-13-1965</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn</b>                    |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Eastern Ave. Bal. Co. Md. 21222</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |   |  |  |
| 25B. NAME OF REGISTRAR<br><b>John J. Duda</b>  |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>3922 Wise Ave. Dundalk, Md. 22</b>                                    |   |  |  |



BIRTH NO.

65

3898

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65

3898

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FRANCES

CAVEY

2. DATE AND HOUR PRONOUNCED DEAD

4/9/65

11:40 a. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

1208 S. Decker Ave.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1208 S. Decker Ave.

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (Specify)  
Married

8. DATE OF BIRTH

Sept. 17- 1921

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Stanialaus Brzezcko

14. MOTHER'S MAIDEN NAME

Catherine Pomykala

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Husband, Francis A. Cavey, # 4, a, b, c, d,

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Rheumatic endocarditis of mitral valve,  
chronic, inactive

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C)

MEDICAL CERTIFICATION

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Werner N. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/9/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

April 12, 1965

23C. NAME of CEMETERY or CREMATORY

St. Stanislaus

23D. LOCATION

(City, town, or county)

(State)

Dundalk, Ave. Bal. Md. 21224

24A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

24B. NAME OF REGISTRAR

Robert E. Fajkus

24C. FUNERAL DIRECTOR

John J. Duda, 2829 Hudson St. Balto. Md. 24

WALLEY FONG

WALLEY FONG

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |   | X  |   |
|--|-------------------------|---|---|--|---|
| BIRTH NO. 65 3899  |                         |   |   | Registered No. 65 3899   |   |
| M.E. CASE NO. 65 3899  |                         |   |   | CERTIFICATE OF DEATH   |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>DIGNAN, Lawrence Thomas</b>  |                         |   | 2. DATE AND HOUR OF DEATH<br><b>April 7, 1965</b> <b>3:35</b> p.m.  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Veterans Administration Hospital</b><br><b>3900 Loch Raven Boulevard</b><br><b>Baltimore, Maryland 21218</b>   |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>Balto 5300</b><br>D. STREET ADDRESS (If rural, give location) <b>8620 Belair Road</b> |  |   |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                                | 8. DATE OF BIRTH<br><b>July 2, 1901</b>   | 9. AGE (In years lost birthday)<br><b>63</b>   | If Under 1 Yr. Months: Days: Hours: Min.<br>If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Steelworker</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Beth. Steel Co.</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>                          |   |
| 13. FATHER'S NAME<br><b>James I Dignan</b>   |                         |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes</b> <b>6/18/42 - 3/4/43</b>   |                         |   | 16. SOCIAL SECURITY NO.<br><b>218-01-2061</b>   |  |   |
| 17. INFORMANT<br><b>VA Hospital Records 3900 Loch Raven Blvd</b><br><b>Baltimore, Maryland 21218</b>   |                         |   | ADDRESS   |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Cor pulmonale</b><br>DUE TO<br><b>Emphysema, Pulmonary, Chronic, Destructive</b>   |                         |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>unknown</b>  |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>II</b>  |                         |   |   |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |   |   |  |   |
| 19A. DATE OF OPERATION<br><b>2</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                         |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>March 4th</b> 19 <b>65</b> to <b>April 7th</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 7th</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |   |  |   |
| 23A. SIGNATURE<br><b>Robert N. DiSimone</b> M.D.   |                         |   |   | 23B. DATE SIGNED<br><b>April 8, 1965</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROBERT N. DiSIMONE</b> M.D.   |                         |   |   | 23D. ADDRESS<br><b>VA Hospital 3900 Loch Raven Boulevard</b><br><b>Baltimore, Maryland 21218</b> |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4-12-1965</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Baltimore National</b>                                  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Frederick Rd. Balto. Md. 21228</b>   |                         |   |   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>John J. Duda</b>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>7922 Wise Ave. Dundalk, Md. 22</b>                           |   |



Robert A. Johnson



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |   |  |   | Registered No. _____   |  |
|--|---|--|---|--|--|
| BIRTH NO. <span style="font-size: 2em;">65 3900</span>   |   | <b>CERTIFICATE OF DEATH</b>  |   |  |  |
| M.E. CASE NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.5em;">KROPKOWSKI, JOSEPH J.</span>        |   | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.5em;">4/18/65</span> <span style="font-size: 1.5em;">9:38 A</span> M. |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><span style="font-size: 1.5em;">South Baltimore General Hospital</span>   |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.5em;">Maryland</span><br>B. COUNTY <span style="font-size: 1.5em;">Baltimore</span><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <span style="font-size: 1.5em;">26-11</span><br>D. STREET ADDRESS (If rural, give location) <span style="font-size: 1.5em;">1191 S. Clinton St.</span> |  |  |
| 5. SEX<br><span style="font-size: 1.5em;">Male</span>  | 6. RACE<br><span style="font-size: 1.5em;">White</span> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.5em;">Married</span> | 8. DATE OF BIRTH<br><span style="font-size: 1.5em;">3/1/94</span>   | 9. AGE (In years last birthday)<br><span style="font-size: 1.5em;">71</span>   | If Under 1 Yr. Months: Days: Hours: Min.                           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.5em;">Longshoreman - Retired</span>   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>_____   |   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.5em;">Poland</span>                                   |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.5em;">Henry A. Kropkowski</span>  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.5em;">U.S.A.</span>   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.5em;">No</span>  |   |  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.5em;">215-09-3422</span>   |  |  |
| 17. INFORMANT<br><span style="font-size: 1.5em;">Wife, Maryanna Kropkowski, # 4,a,b,c,d.</span>  |   |  | ADDRESS   |  |  |
| 18. <span style="font-size: 1.5em;">199.2.1</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><span style="font-size: 1.5em;">Metastatic Carcinoma of prostate site not known</span> |   |  | CAUSE OF DEATH<br>(A) DUE TO _____<br>(B) DUE TO _____<br>(C) DUE TO _____  |  |  |
| INTERVAL BETWEEN ONSET AND DEATH   |   |  |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |  |   |  |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.5em;">O</span>   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.5em;">No</span>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>     |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (this hospital) attended the deceased from <span style="font-size: 1.5em;">4/11/65</span> 19 to <span style="font-size: 1.5em;">4/18/65</span> 19 that (we) last saw the deceased alive on <span style="font-size: 1.5em;">4/18/65</span> 19 and that in (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |   |  |   |  |  |
| 23A. SIGNATURE<br><span style="font-size: 1.5em;">John Weagly</span>   |   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><span style="font-size: 1.5em;">4/18/65</span> |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.5em;">Dr. John Weagly</span>   |   |  | 23D. ADDRESS<br><span style="font-size: 1.5em;">1213 Light Street Balto. Md 21230</span>  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.5em;">Burial</span>  |   | 24B. DATE<br><span style="font-size: 1.5em;">4-12-1965</span>  |   | 24C. NAME of CEMETERY or CREMATORY<br><span style="font-size: 1.5em;">St. Stanislaus</span>                                  |  |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.5em;">Dundalk, Ave. Balto. Md. 21224</span>   |   |  |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.5em;">APR 13 1965</span>  |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.5em;">John J. Duda</span>                              |   | 25C. FUNERAL DIRECTOR ADDRESS<br><span style="font-size: 1.5em;">2829 Hudson St. Balto. Md. 212</span>                       |  |

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## BALTIMORE CITY HEALTH DEPARTMENT

BIRTH NO. **65 3901** MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. **65 3901**  
 M.E. CASE NO.

**1. NAME OF DECEASED** (Type or Print) **FORD EDWARD ALLEN, Sr.** **2. DATE AND HOUR PRONOUNCED DEAD** **April 7, 1965 5:35 P. M.**

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD** **Baltimore City Hospitals** **4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
**A. STATE** **Maryland** **B. COUNTY**

**5. SEX** **Male** **6. RACE** **White** **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)** **Married** **8. DATE OF BIRTH** **Sept. 14, 1918** **9. AGE (In years last birthday)** **46** **10. USUAL OCCUPATION** (Give kind of work done during most of working life. Leave if retired.) **Formerly employed at Rheem Mfg. Co.** **11. BIRTHPLACE** (State or foreign country) **North Carolina** **12. CITIZEN OF WHAT COUNTRY?** **U.S.A.**

**13. FATHER'S NAME** **Robert Allen** **14. MOTHER'S MAIDEN NAME** **Lodiskey Young**

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no or unknown) (If yes, give war or dates of service) **No** **16. SOCIAL SECURITY NO.** **237-16-0540** **17. INFORMANT** **Wife, Mrs. Dorothy Allen, # 4,a,b,c,d.** **ADDRESS**

**18. CAUSE OF DEATH** **INTERVAL BETWEEN ONSET AND DEATH**

**I**  
**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH**  
 (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  
**(A) DUE TO** **Arteriosclerotic Heart Disease.**

**II**  
**OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.**

**19A. DATE OF OPERATION** **2** **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY? (Yes or No)** **Yes** **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?** **Yes**

**21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.** **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME OF INJURY (APPROX.)** (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** **21F. HOW DID INJURY OCCUR?**

**22. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐**

**ACTUAL SIGNATURE** **EXAMINER'S NAME (Type)** **Charles S. Petty, M.D.** **CHIEF MEDICAL EXAMINER ☐** **ASSISTANT MEDICAL EXAMINER ☒** **ASSOCIATE MEDICAL EXAMINER ☐** **DATE SIGNED** **4/8/65**

**23A. BURIAL CREMATION, REMOVAL (Specify)** **Burial** **23B. DATE** **April 10-1965** **23C. NAME of CEMETERY or CREMATORY** **Oak Lawn** **23D. LOCATION** (City, town, or county) (State) **Eastern Ave. Bal. Co. Md. 21222**

**24A. DATE REC'D BY HEALTH DEPT.** **APR 13 1965** **24B. NAME OF REGISTRAR** **Robert E. Farber** **24C. FUNERAL DIRECTOR** **JOHN J. DUDA** **ADDRESS** **7922 Wise Ave. Dundalk, Md. 22**

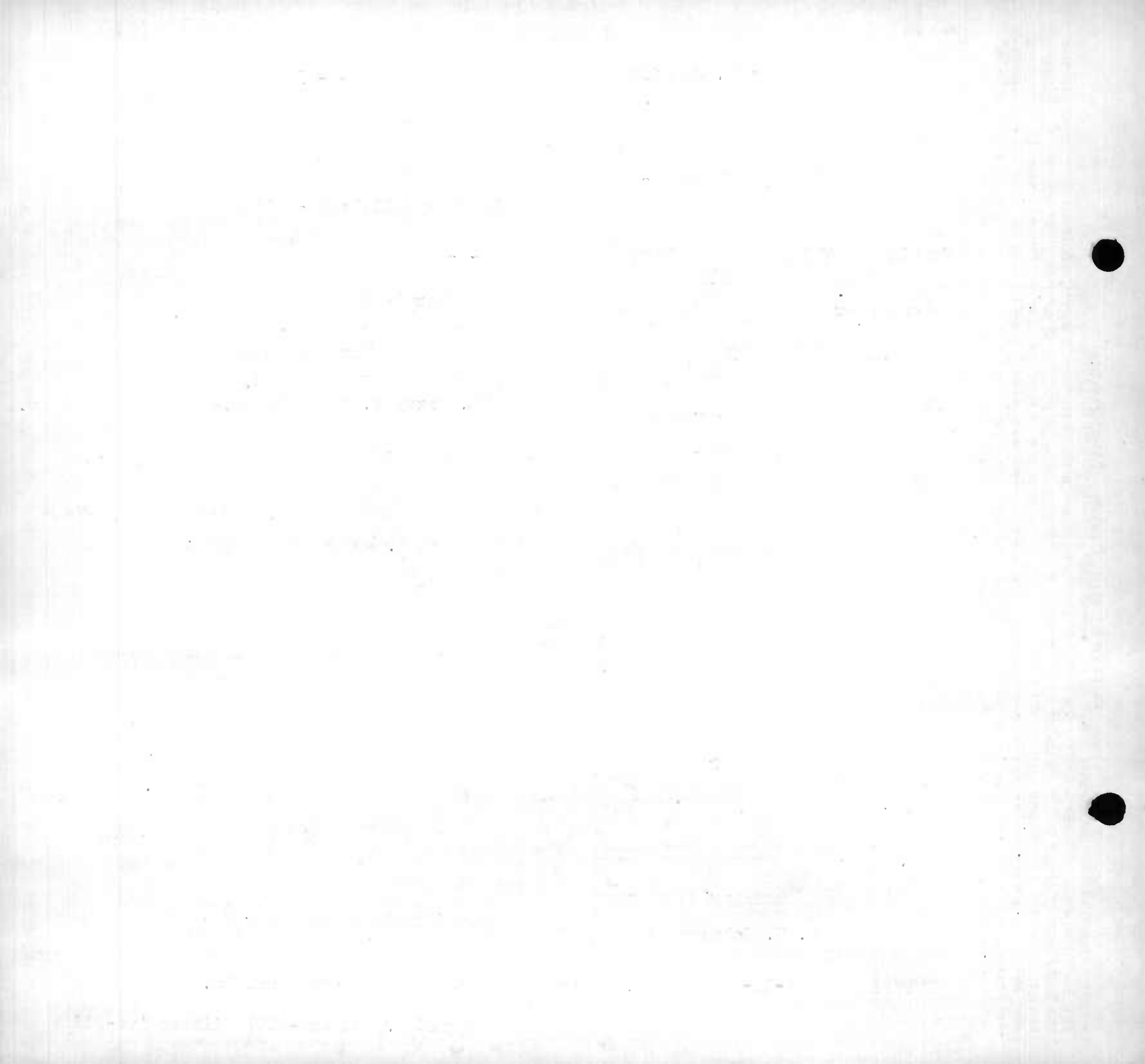
WALLINGTON

IPAD CONTEST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

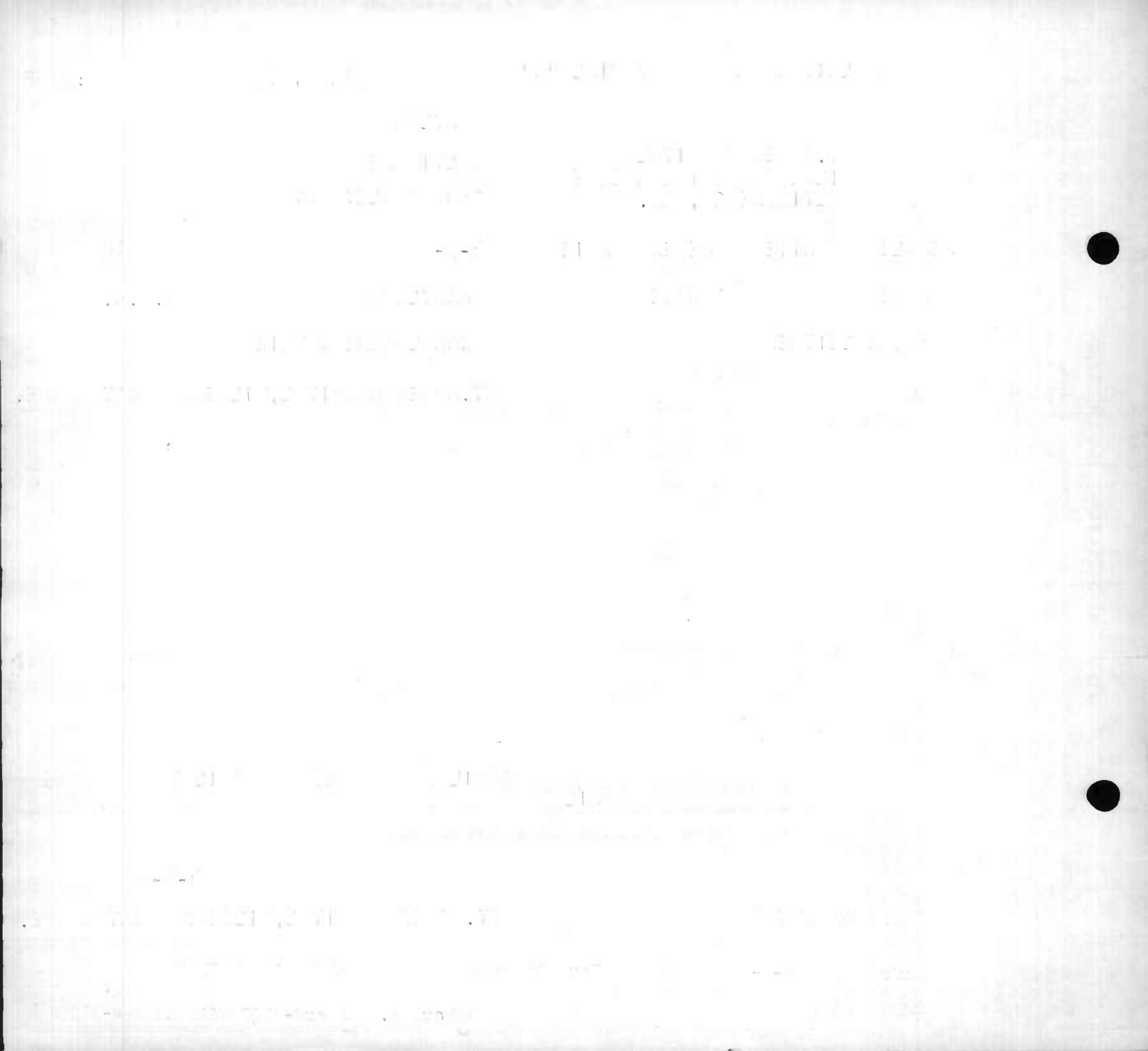
|  |                         |  |   |  |   |
|--|-------------------------|--|---|--|---|
| BIRTH NO. 65 3902  |                         | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>  |   | Registered No. 65 3902   |   |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print) <b>Edna M. Schmidt</b>   |                         |  | 2. DATE AND HOUR OF DEATH<br><b>4-8-65</b>  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>302 Marydell Road - 21229</b>  |                         |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>25-31</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>302 Marydell Road - 21229</b> |  |   |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Married</b>                               | 8. DATE OF BIRTH<br><b>9-4-95</b>   | 9. AGE (In years last birthday)<br><b>69</b>                             | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |   |
| 12. CITIZEN OF WHAT COUNTRY?   |                         |  | 13. FATHER'S NAME<br><b>Louis Fay</b>   |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Mary Thater</b>   |                         |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |
| 16. SOCIAL SECURITY NO.  |                         |  | 17. INFORMANT<br><b>Elkridge, Md. 21227</b><br><b>Mr. Harry F. Schmidt, Sr.-c/o 9 Pheasant Dr.</b>  |  |   |
| 18. <b>420.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Coronary Thrombosis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Arteriosclerosis Cardio-Vascular Disease &amp; Coronary Insufficiency</b> |                         |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Sudden</b><br><b>16 years</b>  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>5/10</b> <b>1945</b> to <b>4/8</b> <b>1965</b> , that (I) (we) last saw the deceased alive on <b>4/4</b> <b>1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <input checked="" type="checkbox"/> (did not) view the body after death. <b>4/8/65 2:45 PM</b>   |                         |  |   |  |   |
| 23A. SIGNATURE<br><b>E. W. Johnson</b>   |                         |  | 23B. DATE SIGNED  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>E. W. Johnson</b>              |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         |  | 24B. DATE<br><b>4-12-65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Loudon Park Cemetery</b> |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>   |                         |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |  |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Jackson</b>   |                         |  | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard-4107 Wilkens Ave-21229</b>  |  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3903  |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3903   |  |
|--|--|--|--|--|--|--|--|
| M.E. CASE NO. 65 3903  |  |  |  | 1. NAME OF DECEASED (Type or Print) LEITNER  |  | 2. DATE AND HOUR OF DEATH APRIL 7, 1965 7:35 P.                      |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. AGNES HOSPITAL WILKENS & CATON AVENUE BALTIMORE 29, MD.  |  |  |  | A. STATE MARYLAND B. COUNTY 25-42  |  |  |  |
|  |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE  |  |  |  |
|  |  |  |  | D. STREET ADDRESS (If rural, give location) 2807 GANLEY DRIVE  |  |  |  |
| 5. SEX FEMALE  |  | 6. RACE WHITE  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) NEVER MARRIED   |  | 8. DATE OF BIRTH 4-7-65  |  |
|  |  |  |  |  |  | 9. AGE (In years last birthday) 10                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE   |  | 10B. KIND OF BUSINESS OR INDUSTRY NONE   |  | 11. BIRTHPLACE (State or foreign country) MARYLAND   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.                                  |  |
| 13. FATHER'S NAME FRANK LEITNER  |  |  |  | 14. MOTHER'S MAIDEN NAME CAROL ANNE DOWNIE   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO  |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.       |  |
| 18. 226 X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  |  |  | CAUSE OF DEATH Imaturity   |  | INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  | (A) DUE TO   |  |  |  |
|  |  |  |  | (B) DUE TO   |  |  |  |
|  |  |  |  | (C) DUE TO   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION 0   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 7 1965 to APRIL 7 1965, that (I) (we) last saw the deceased alive on APRIL 7 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |  |  |
| 23A. SIGNATURE Grace P. Ayuyao   |  |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED 4-8-65  |  |
| 23C. PHYSICIAN'S NAME (Type) GRACE AYUYAO  |  |  |  | 23D. ADDRESS ST. AGNES HOSPITAL, WILKENS & CATON AVE.  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE 4-9-65   |  | 24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery  |  | 24D. LOCATION (City, town, or county) (State) Baltimore, Maryland    |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 13 1965  |  | 25B. NAME OF REGISTRAR Robert E. Talbot  |  | 25C. FUNERAL DIRECTOR Howard H. Hubbard  |  | ADDRESS 4107 Wilkens Ave-21229                                       |  |

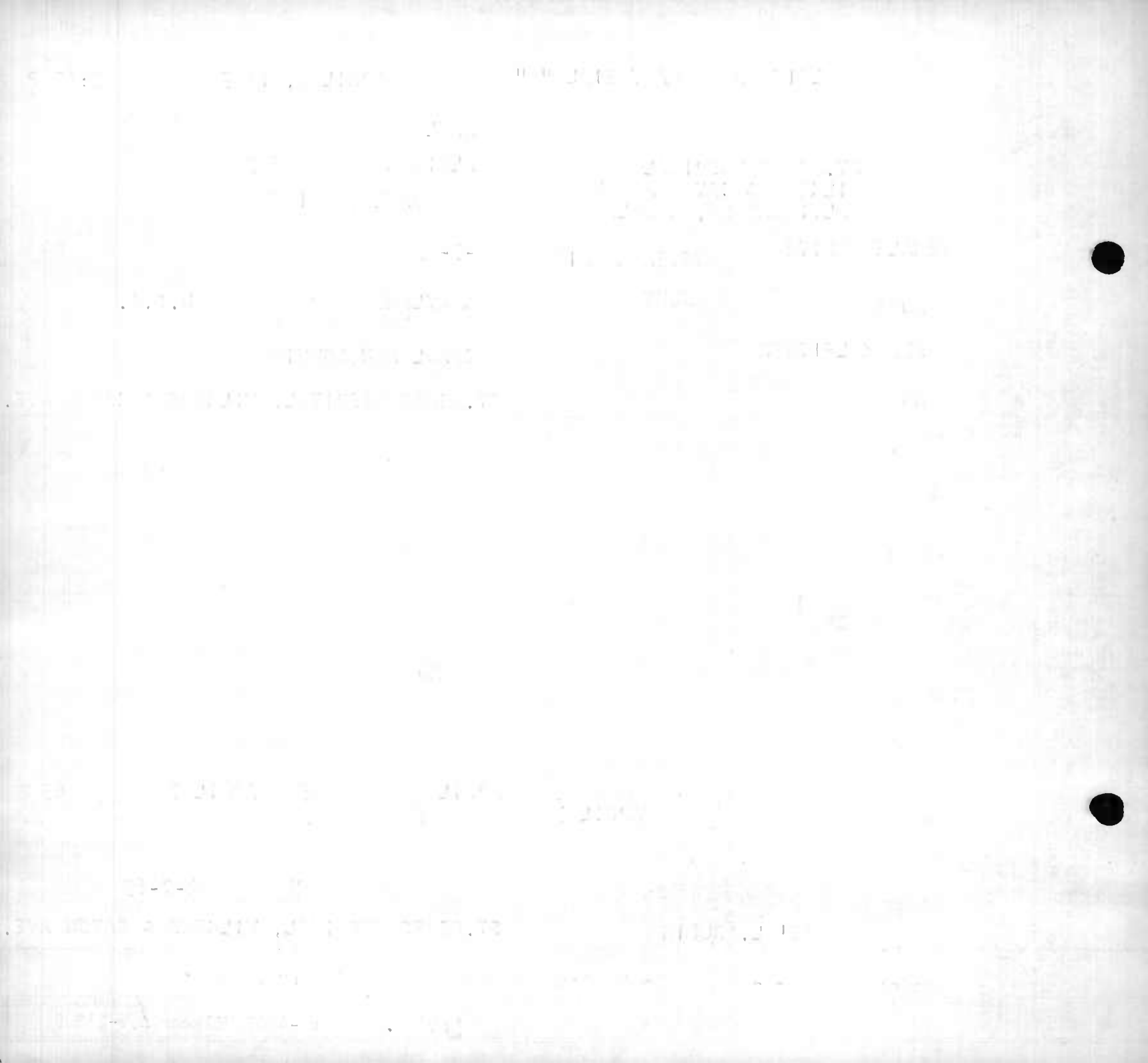




# FUNERAL DIRECTOR: IMPORTANT

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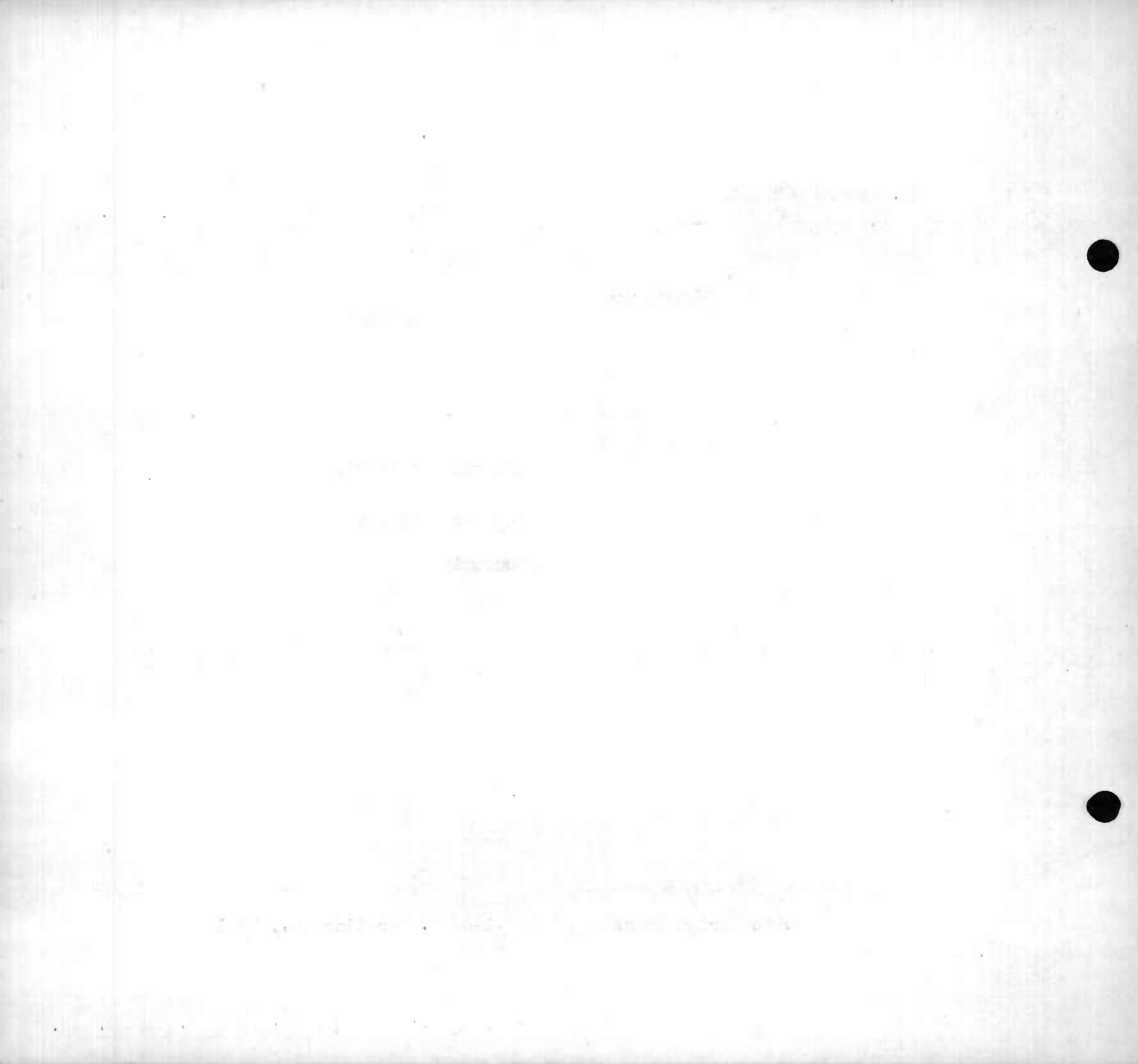
|   |                  |  |   |   |   |
|---|------------------|--|---|---|---|
| BIRTH NO.<br>65 3904  |                  | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3904  |   |
| M.E. CASE NO.   |                  | CERTIFICATE OF DEATH   |   |   |   |
| 1. NAME OF DECEASED<br>(Type or Print)  |                  | LEITNER BABY GIRL "B"  |   | 2. DATE AND HOUR OF DEATH<br>APRIL 7, 1965 3:35 P.                        |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |   |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>ST. AGNES HOSPITAL<br>WILKENS & CATON AVENUE<br>BALTIMORE 29, MARYLAND  |                  | A. STATE<br>MARYLAND   |   | B. COUNTY<br>25-42  |   |
|   |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                                |   | BALTIMORE ZONE 30   |   |
|   |                  | D. STREET ADDRESS (If rural, give location)  |   | 2807 GANLEY DRIVE   |   |
| 5. SEX<br>FEMALE  | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>NEVER MARRIED                              | 8. DATE OF BIRTH<br>4-7-65  | 9. AGE (In years lost birthday)   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  | 11. BIRTHPLACE (State or foreign country)                         | 12. CITIZEN OF WHAT COUNTRY?  |   |
| NONE  |                  | NONE   | MARYLAND  | U.S.A.  |   |
| 13. FATHER'S NAME<br>FRANK LEITNER  |                  |  | 14. MOTHER'S MAIDEN NAME<br>CAROL ANN DOWNIE                      |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |                  | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS<br>ST. AGNES HOSPITAL, WILKENS & CATON AVE. |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.       |                  | CAUSE OF DEATH<br>(A) IMMATUREITY<br>(B) DUE TO<br>(C)   |   | INTERVAL BETWEEN ONSET AND DEATH<br>6 hrs. 4 min.                         |   |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |   |   |   |
| 19A. DATE OF OPERATION<br>0   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br>NO   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from APRIL 7 19 65 to APRIL 7 19 65, that (I) (we) last saw the deceased alive on APRIL 7 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |  |   |   |   |
| 23A. SIGNATURE<br>Fe' L. Rubin  |                  |  |   | 23B. DATE SIGNED<br>4-7-65  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>FE' L. RUBIN  |                  |  |   | 23D. ADDRESS<br>ST. AGNES HOSPITAL, WILKENS & CATON AVE.                  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4-9-65  |   | 24C. NAME of CEMETERY or CREMATORY<br>Loudon Park Cemetery                |   |
|   |                  |  |   | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland      |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 13 1965  |                  | 25B. NAME OF REGISTRAR<br>R. E. Felt   |   | 25C. FUNERAL DIRECTOR ADDRESS<br>Howard H. Hubbard-4107 Wilkens Ave-21229 |   |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY DEPARTMENT<br>CERTIFICATE OF DEATH  |   |   |  | Registered No. <span style="font-size: 1.2em;">65 3905</span>  |  |
|--|---|---|--|--|--|
| BIRTH NO. <span style="font-size: 1.2em;">65 3905</span>   |   | M.E. CASE NO.   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.1em;">WALKER, ANNA</span>   |   |   | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.1em;">April 12, 1965</span>   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><br><span style="font-size: 1.1em;">ST. JOSEPH HOSPITAL</span>  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.1em;">Md.</span> B. COUNTY <span style="font-size: 1.1em;">7-02</span>                           |  |  |
|  |   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.1em;">Baltimore 24 510 N. Kenwood Ave.</span>   |  |  |
|  |   |   | D. STREET ADDRESS (If rural, give location)<br><span style="font-size: 1.1em;">Shore #8 Riverside &amp; Eastern Aves.</span>   |  |  |
| 5. SEX<br><span style="font-size: 1.1em;">Female</span>  | 6. RACE<br><span style="font-size: 1.1em;">White</span>     | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.1em;">Widowed</span>  | 8. DATE OF BIRTH<br><span style="font-size: 1.1em;">12/21/87</span>  | 9. AGE (In years last birthday)<br><span style="font-size: 1.1em;">77</span>                                   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.1em;">Homemaker</span>                     | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.1em;">Germany</span>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.1em;">USA</span> |
| 13. FATHER'S NAME<br><span style="font-size: 1.1em;">Unknown</span>  |   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.1em;">Unknown</span>   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.1em;">No</span>  |   | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.1em;">None</span>                                    | 17. INFORMANT<br><span style="font-size: 1.1em;">Mrs. Mary Christian 510 N. Kenwood Ave</span>   |  |  |
| 18. <span style="font-size: 1.2em;">260X I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   |   | CAUSE OF DEATH<br>(A) <span style="font-size: 1.1em;">Cerebral thrombosis</span><br>DUE TO<br>(B) <span style="font-size: 1.1em;">Diabetes mellitus</span><br>DUE TO<br>(C) <span style="font-size: 1.1em;">Pneumonia</span> |  |  |
| INTERVAL BETWEEN ONSET AND DEATH   |   |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |   |  |  |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.1em;">0</span>   |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.1em;">No</span>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                       |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |   | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">4/9</span> 19 <span style="font-size: 1.1em;">65</span> to <span style="font-size: 1.1em;">4/12</span> 19 <span style="font-size: 1.1em;">65</span> , that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">4/12</span> 19 <span style="font-size: 1.1em;">65</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |   |  |  |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Sukho Viriyapongse</span> M.D.   |   |   | 23B. DATE SIGNED<br><span style="font-size: 1.1em;">4/12/65</span>   |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.1em;">Sukho Viriyapongse</span>  |   |   | 23D. ADDRESS<br>M.D. <span style="font-size: 1.1em;">1400 N. Caroline St., 21213</span>  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.1em;">Burial</span>  | 24B. DATE<br><span style="font-size: 1.1em;">4/15/65</span> | 24C. NAME of CEMETERY or CREMATORY<br><span style="font-size: 1.1em;">Sacred Heart Cemetery</span>        |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.1em;">Baltimore, Maryland</span>    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.1em;">APR 13 1965</span>  |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.1em;">Robert E. Farkas</span>                         |  | 25C. FUNERAL DIRECTOR ADDRESS<br><span style="font-size: 1.1em;">John A. Moran, Inc. 3000 E. Balto. St.</span> |  |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |                         |  |  | Registered No. 65 3906   |  |
|--|-------------------------|--|--|--|--|
| BIRTH NO. 65 3906  |                         | <b>CERTIFICATE OF DEATH</b>  |  |  |  |
| M.E. CASE NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>ANNA M. PATTERSON</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>4-11-65 2:35 P.M.</b>                          |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                              |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>MARYLAND GENERAL HOSP.</b><br><b>BALTO MD</b>   |                         | A. STATE <b>MD</b><br>B. COUNTY <b>BALTO.</b>  |  |  |  |
|  |                         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTO.</b>                           |  | <b>53-00</b>   |  |
|  |                         | D. STREET ADDRESS (If rural, give location)<br><b>Apt 29 Edgewater Apts.</b>                                       |  |  |  |
| 5. SEX<br><b>F.</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)   |  | 8. DATE OF BIRTH<br><b>8/21/09</b>   | 9. AGE (In years last birthday)<br><b>55</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br>—   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>                   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |
| 13. FATHER'S NAME<br><b>WILLIAM P. GESSNER</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>LILLIAN Maully</b>  |  | 17. INFORMANT<br><b>Mr. John L. Patterson Apt. 29, Edgewater</b>               |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>None</b>   |  | ADDRESS<br><b>Apt. 29, Edgewater</b>   |  |
| 18. <b>422.11</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>   |                         | CAUSE OF DEATH<br>(A) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>(B) <b>Pulmonary embolization</b><br>(C) — |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>4 yrs.</b>                              |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                         |  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>—  |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>—                      |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>—  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>—   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>          |  | 21F. HOW DID INJURY OCCUR?<br>—  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 1961</b> to <b>4-11 1965</b> , that (I) (we) last saw the deceased alive on <b>4-11 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                         |  |  |  |  |
| 23A. SIGNATURE<br><b>Frank G. Kuehn</b>  |                         |  |  | 23B. DATE SIGNED<br><b>4/11/65</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>FRANK G. KUEHN</b>  |                         | 23D. ADDRESS<br><b>721 MED ARTS BLDG.</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>                 |  |
|  |                         |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Farber</b>  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>John A. Moran, Inc. 3000 E. Balto. St.</b> |  |

1945-46

F. WHITE

WILSON P. GELDER

NO

2/21/02

WILSON

LILLIAN

WILSON P. GELDER

Y-2

4-11

FRANK G. KUHN

151 MED BATT BDE.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65





BIRTH NO.

65 3908  
65.0540

MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 3908

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

JOYCE MROZINSKI

2. DATE AND HOUR PRONOUNCED DEAD

April 6, 1965

7:30 A. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)

CHURCH HOME &amp; HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

731 S. Montford Avenue

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

3-14-65

9. AGE (In years  
last birthday)If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

23

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State, or foreign country)

MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

JOHN MROZINSKI

14. MOTHER'S MAIDEN NAME

MARY JANE CATALANO

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown; (If yes, give war or dates of service))

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

JOHN MROZINSKI

SAME

18.

763.0 I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial pneumonitis  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL

SIGNATURE

EXAMINER'S

NAME (Type)

M.D.

John E. Adams, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-6-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-7-65

23C. NAME of CEMETERY or CREMATORY

HOLT ROSARY

23D. LOCATION

BALTO. CT.

(City, town, or county)

(State)

MD.

24A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

RAYMOND L. KACZOROWSKI

2535 Fleet St 21224

VALLEY FOUNTAIN

Call N-22 Hill Road, Ball of

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

65 3909

BIRTH NO.

65 3909

M.E. CASE NO.

1. NAME OF DECEASED

(Type or Print)

Melvina Louise Fairbrothers

2. DATE AND HOUR OF DEATH

Apr. 11, 1965

9:10 P

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF HOSPITAL OR INSTITUTION

(If not in hospital or institution, give street address or location)

US Public Health Service Hospital  
Wyman Pk. Drive & 31st St.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Joppatowne

D. STREET ADDRESS (If rural, give location)

738 Joppa Farm Road

5. SEX

F

6. RACE

W

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widow

8. DATE OF BIRTH

9/6/78

9. AGE (in years last birthday)

86

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pa.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

William Wischman

14. MOTHER'S MAIDEN NAME

Anna Miller

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

?

17. INFORMANT

ADDRESS

US PHS Hospital Records, Balto, Md.

18. 420.1 I

CAUSE OF DEATH

INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) DUE TO Coronary artery sclerosis with narrowing

Unknown

(B) DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I/this hospital) attended the deceased from Mar. 31 1965 to Apr. 11 1965, that (I) (we) last saw the deceased alive on Apr. 11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/We) (did) (did not) view the body after death.

23A. SIGNATURE

*Aaron Lupovitch*

M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

4/12/65

23C. PHYSICIAN'S NAME (Type)

Aaron Lupovitch, Surgeon (R)

M.D.

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

4/15/65

24C. NAME of CEMETERY or CREMATORY

SALEM CEMETERY

24D. LOCATION

(City, town, or county)

(State)

PLEASANTVILLE, NEW JERSEY

25A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

HOWARD H. HUBBARD

ADDRESS

4107 WILKENS AVE. 21229

THE UNIVERSITY OF CHICAGO  
DIVISION OF THE PHYSICAL SCIENCES

James Watson  
James Watson

IN THE DEPARTMENT OF PHYSICS

CHICAGO, ILLINOIS

APRIL 1954

( )

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3910  |                  |  |                  | BALTIMORE CITY HEALTH DEPARTMENT   |                              | Registered No. 65 3910   |                            |
|--|------------------|--|------------------|--|------------------------------|--|----------------------------|
| M.E. CASE NO.  |                  |  |                  | CERTIFICATE OF DEATH   |                              |  |                            |
| 1. NAME OF DECEASED<br>(Type or Print) BENJAMIN BERYL COHEN  |                  |  |                  | 2. DATE AND HOUR OF DEATH<br>APRIL 10, 1965 4:15 A.M.  |                              |  |                            |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><br>SINAI HOSPITAL  |                  |  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY 27-20<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE<br>D. STREET ADDRESS (If rural, give location)<br>2709 HANSON AVENUE |                              |  |                            |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br>SEPARATED                                    | 8. DATE OF BIRTH | 9. AGE (In years last birthday)<br>61  | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.   |                            |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>OWNER-BARTENDER   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>TAVERN  |                  | 11. BIRTHPLACE (State or foreign country)<br>RUSSIA  |                              | 12. CITIZEN OF WHAT COUNTRY?<br>USA                                  |                            |
| 13. FATHER'S NAME<br>DAVID COHEN   |                  |  |                  | 14. MOTHER'S MAIDEN NAME<br>SARAH ?  |                              |  |                            |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT<br>MRS. SUZANNE GORDON   |                              |  | ADDRESS<br>2709 HANSON AVE |
| 18. 420.1 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>ACUTE MYOCARDIAL INFARCTION<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                  |  |                  | (A) DUE TO<br>ACUTE MYOCARDIAL INFARCTION<br>(B) DUE TO<br>ARTHRITIS RHEUMATICA (C.V.D.)<br>(C) DUE TO   |                              | INTERVAL BETWEEN ONSET AND DEATH<br>1/2 hr.<br>5 years               |                            |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                            |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                              |  |                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                  | 21F. HOW DID INJURY OCCUR?   |                              |  |                            |
| 22. I certify that (I) (this hospital) attended the deceased from 2/19/1960 to 4/10/65 1965 that (I) (we) last saw the deceased alive on 4/3/1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.   |                  |  |                  |  |                              |  |                            |
| 23A. SIGNATURE<br>A. A. SILVER   |                  |  |                  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                              | 23B. DATE SIGNED<br>4/10/65  |                            |
| 23C. PHYSICIAN'S NAME (Type)<br>A. A. SILVER   |                  |  |                  | 23D. ADDRESS<br>TEMPLE GARDEN APTMENTS   |                              |  |                            |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>4/11/65   |                  | 24C. NAME OF CEMETERY or CREMATORY<br>BETH TFILOH  |                              | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE MARYLAND  |                            |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 23 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Schickel   |                  | 25C. FUNERAL DIRECTOR<br>SQL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD   |                              |  |                            |

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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |                                       | Registered No. 65 3911  |   |
|---|-------------------------|--|---------------------------------------|---|---|
| BIRTH NO. 65 3911   |                         | <b>CERTIFICATE OF DEATH</b>  |                                       |   |   |
| M.E. CASE NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Irvin Rosenthal</i>  |                                       | 2. DATE AND HOUR OF DEATH<br><i>4/9/65 5<sup>30</sup> AM M.</i>                             |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MD.</i> B. COUNTY <i>Balt.</i>  |                                       | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>SINAI HOSPITAL</i>   |                         | D. STREET ADDRESS (If rural, give location)<br><i>5802 Stuart Ave</i>  |                                       |   |   |
| 5. SEX<br><i>MALE</i>   | 6. RACE<br><i>WHITE</i> | 7. <del>MARRIED</del> NEVER MARRIED<br><i>WIDOWED</i> (specify)  | 8. DATE OF BIRTH<br><i>11/10/1909</i> | 9. AGE (In years last birthday)<br><i>55</i>  | If Under 1 Yr. Months: Days: Hours: Min.      |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Real Estate Broker</i>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |                                       | 11. BIRTHPLACE (State or foreign country)<br><i>NEW YORK</i>                                | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i> |
| 13. FATHER'S NAME<br><i>SAM ROSENTHAL</i>   |                         | 14. MOTHER'S MAIDEN NAME<br><i>DORA BRACHMAN</i>   |                                       |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>NO</i>   |                         | 16. SOCIAL SECURITY NO.<br><i>215-34-1900</i>  |                                       | 17. INFORMANT<br><i>MRS. NINA ROSENTHAL</i> ADDRESS<br><i>5802 STUART AVE</i>               |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><i>Metastatic carcinoma of the Colon</i>   |                         | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C)  |                                       | INTERVAL BETWEEN ONSET AND DEATH<br><i>May 1964 - April 1965</i>                            |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |                                       |   |   |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                       | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                    |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                                       | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>3/24</i> 19 <i>65</i> to <i>4/9</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4/9</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                       |   |   |
| 23A. SIGNATURE<br><i>Donald Rice</i>  |                         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                                       | 23B. DATE SIGNED<br><i>4/9/65</i>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>DONALD RICE</i>  |                         | 23D. ADDRESS<br><i>Sinai Hosp.</i>   |                                       |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>BURIAL</i>   |                         | 24B. DATE<br><i>4/11/65</i>  |                                       | 24C. NAME OF CEMETERY or CREMATORY<br><i>MISHKON ISRAEL</i>                                 |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>BALTIMORE MARYLAND</i>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 13 1965</i>  |                                       | 25B. NAME OF REGISTRAR<br><i>SOL. LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</i>        |   |
| 25C. FUNERAL DIRECTOR ADDRESS   |                         | 25D. NAME OF REGISTRAR   |                                       | 25E. NAME OF REGISTRAR  |   |



THE UNITED STATES

OFFICE

OF THE

SECRETARY OF THE

NAVY

AND THE

DEPARTMENT OF THE

NAVY

OFFICE

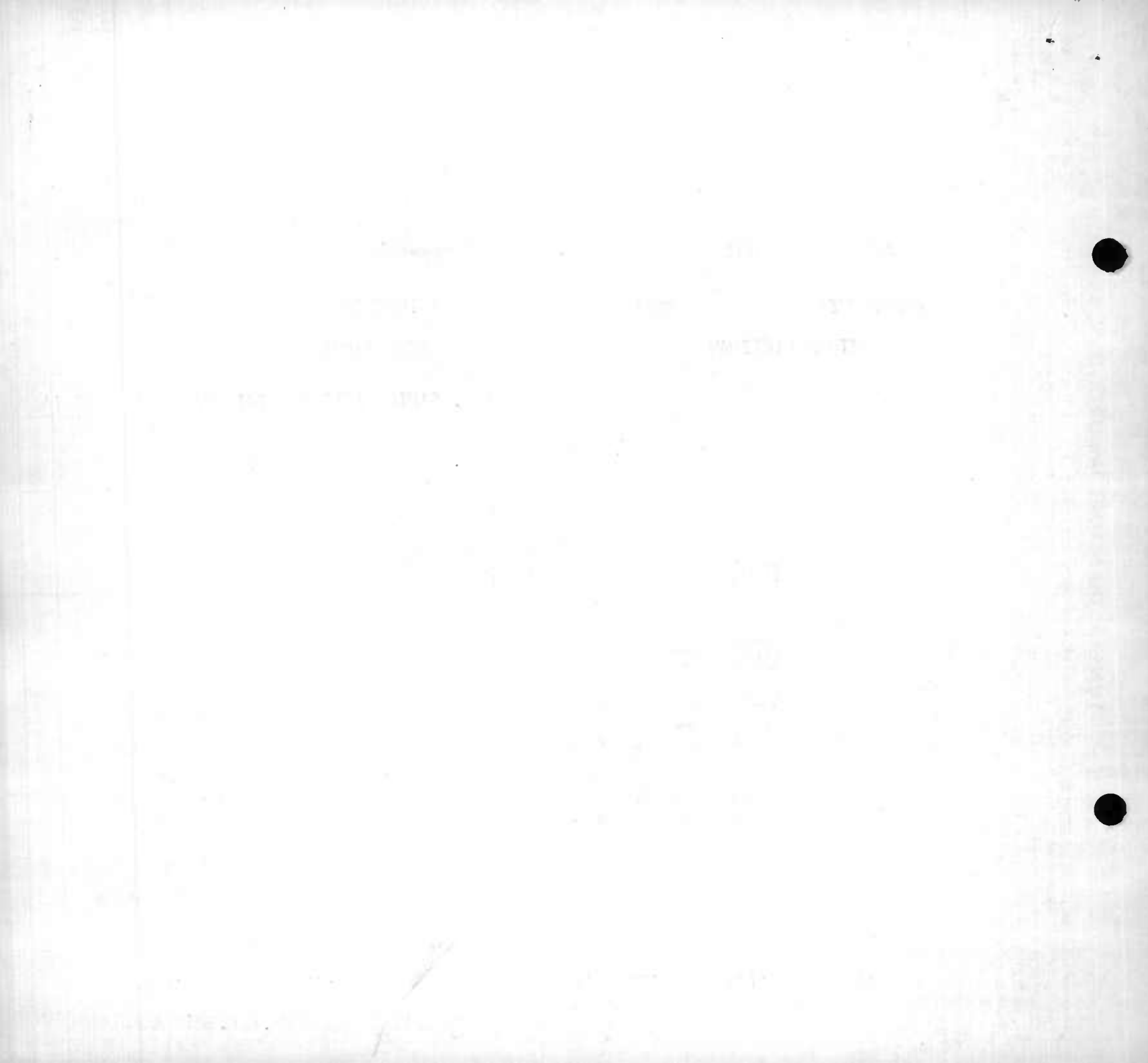
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

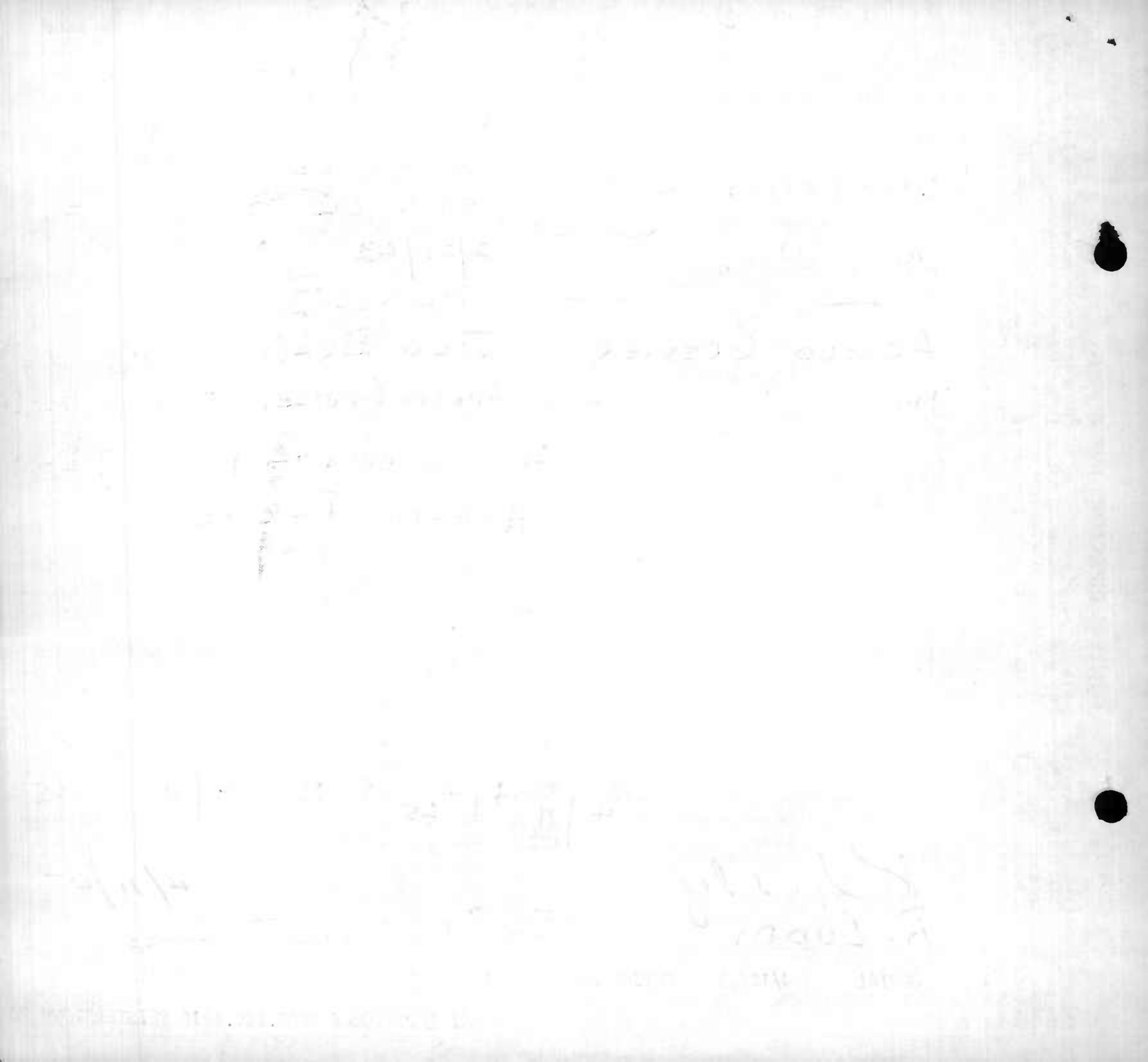
| BIRTH NO.  |                        | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No.   |  |
|--|------------------------|--|---|--|--|
| 65 3912  |                        | CERTIFICATE OF DEATH   |   | 65 3912  |  |
| M.E. CASE NO.  |                        |  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |                        |  | 2. DATE AND HOUR OF DEATH   |  |  |
| Klotzman, Max  |                        |  | 4/10/65 1420 AM   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                        |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                     |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)   |                        |  | A. STATE B. COUNTY  |  |  |
| Sinai Hospital of Balto Inc  |                        |  | Md. Balto 27-20   |  |  |
|  |                        |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                                   |  |  |
|  |                        |  | Balto   |  |  |
|  |                        |  | D. STREET ADDRESS (If rural, give location)   |  |  |
|  |                        |  | 2916 Taney Rd   |  |  |
| 5. SEX   | 6. RACE                | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| MALE   | WHITE                  | MARRIED  |   | 60   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                        | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)                                |  |
| PAWNBROKER   |                        | RETAIL   |   | LITHUANIA  |  |
| 13. FATHER'S NAME  |                        |  | 12. CITIZEN OF WHAT COUNTRY?  |  |  |
| NATHAN KLOTZMAN  |                        |  | USA   |  |  |
| 14. MOTHER'S MAIDEN NAME   |                        |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) |  |  |
| ROSE JACOBS  |                        |  | NO  |  |  |
| 16. SOCIAL SECURITY NO.  |                        |  | 17. INFORMANT ADDRESS   |  |  |
|  |                        |  | MRS. SADIE KLOTZMAN 2918 TANEY RD APT 1A  |  |  |
| 18. 420.11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |                        |  | CAUSE OF DEATH  |  |  |
|  |                        |  | Acute Myocardial Infarct  |  |  |
| ANTECEDENT CAUSES  |                        |  | (A) DUE TO  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                        |  | (B) DUE TO  |  |  |
|  |                        |  | HASCVD  |  |  |
|  |                        |  | (C)   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                        |  |   |  |  |
| 19A. DATE OF OPERATION   |                        | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  |
| D  |                        |  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                        | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |                        |  |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                        | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
|  |                        |  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4/10/65 12:45 PM to 4/10/65 7:20 AM that (I) (we) last saw the deceased alive on 4/10/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                        |  |   |  |  |
| 23A. SIGNATURE   |                        |  | 23B. DATE SIGNED  |  |  |
| Thomas L. Feher M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                        |  | 4/10/65   |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |                        |  | 23D. ADDRESS  |  |  |
| Thomas L. Feher M.D.   |                        |  | Sinai Hospital of Balto.  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE              | 24C. NAME OF CEMETERY or CREMATORY   |   | 24D. LOCATION (City, town, or county) (State)                            |  |
| BURIAL   | 4/11/65                | AITZ CHAIM   |   | BALTIMORE MARYLAND   |  |
| 25A. DATE REC'D BY HEALTH DEPT.  | 25B. NAME OF REGISTRAR | 25C. FUNERAL DIRECTOR ADDRESS  |   |  |  |
| APR 13 1965  | Rebecca J. Feher       | SOJ LEVINSON & BROS. INC. 6010 REISTERSTOWN RD   |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                             |   |  |   |   |
|--|-----------------------------|---|--|---|---|
| BIRTH NO. <u>62-04353</u><br><u>65 3913</u>  |                             | <b>CERTIFICATE OF DEATH</b>   |  | Registered No. <u>65 3913</u>   |   |
| M.E. CASE NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <u>STEVEN SIMON GRESSER</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>4/11/65</u> <u>12:00 P</u> M.   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD.</u><br>B. COUNTY <u>Balt</u> |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>BALTIMORE</u> <u>6300</u> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>UNIVERSITY HOSP.</u>  |                             | D. STREET ADDRESS (If rural, give location)<br><u>8316 OLD POST DRIVE</u>   |  |   |   |
| 5. SEX<br><u>M</u>   | 6. RACE<br><u>W</u>         | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED<br>WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH<br><u>2/20/62</u>                 | 9. AGE (In years lost birthday) <u>3</u>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.</u>               |
| 13. FATHER'S NAME<br><u>ARNOLD GRESSER</u>   |                             |   | 14. MOTHER'S MAIDEN NAME<br><u>JOAN BRAUNSTEIN</u> |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                             | 16. SOCIAL SECURITY NO.<br><u>—</u>   |  | 17. INFORMANT ADDRESS<br><u>ARNOLD GRESSER 8316 OLD POST DR</u>   |   |
| 18. <u>583X1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                             | CAUSE OF DEATH<br>(A) <u>HYPOGLYCEMIA + ACIDOSIS</u><br>DUE TO<br>(B) <u>HEPATIC FAILURE</u><br>DUE TO<br>(C) <u>?</u>                |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>7 DAYS</u>   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                             |   |  |   |   |
| 19A. DATE OF OPERATION<br><u>2</u>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                     |  | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased, from <u>4/11/65</u> to <u>4/11/65</u> , that (I) (we) last saw the deceased alive on <u>4/11/65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                               |                             |   |  |   |   |
| 23A. SIGNATURE<br><u>K. Luddy</u>  |                             | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>             |  | 23B. DATE SIGNED<br><u>4/11/65</u>  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><u>K. Luddy</u>  |                             | 23D. ADDRESS<br><u>University Hosp</u>  |  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  | 24B. DATE<br><u>4/12/65</u> | 24C. NAME of CEMETERY or CREMATORY<br><u>CHIZUK AMUNO (ARLINGTON)</u>   |  | 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE MARYLAND</u>                              |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 13 1965</u>  |                             | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor</u>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><u>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD</u>              |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |   | Registered No. 65 3914   |  |
|--|--|--|---|--|--|
| BIRTH NO. 65 3914  |  | CERTIFICATE OF DEATH   |   |  |  |
| M.E. CASE NO. 1. NAME OF DECEASED (Type or Print) SAMUEL K. HORNSTEIN  |  |  | 2. DATE AND HOUR OF DEATH APRIL 11, 1965 12:45 AM   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND (If not in hospital or institution, give street address or location) MONTEBELLO STATE HOSPITAL  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 15-11 |  |  |
| 5. SEX MALE 6. RACE WHITE 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED   |  |  | 8. DATE OF BIRTH 10/19/1886 9. AGE (In years last birthday) 78  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business Executive   |  |  | 11. BIRTHPLACE (State or foreign country) MARYLAND  |  |  |
| 10B. KIND OF BUSINESS OR INDUSTRY Television Parts CONSTRUCTION MATERIALS  |  |  | 12. CITIZEN OF WHAT COUNTRY? U. S. A.   |  |  |
| 13. FATHER'S NAME KALSMAN HORNSTEIN  |  |  | 14. MOTHER'S MAIDEN NAME CAROLINE ?   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Not Known   |  |  | 16. SOCIAL SECURITY NO. XXXXX 217-18-0979   |  |  |
| 17. INFORMANT ADDRESS MRS. GOLDIE HORNSTEIN 3301 DORITHAN RD   |  |  |   |  |  |
| 18. 332X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the immediate cause of death, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  |  | CAUSE OF DEATH  |  |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  | (A) CEREBRAL THROMBOSIS (B) AFTERIOSELOSIS, LEFT MIDDLE CEREBRAL ARTERY (C)   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |   |  |  |
| 19A. DATE OF OPERATION 0   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No) NO   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)     |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from February 1 19 65 to April 11 19 65, that (I) (we) last saw the deceased alive on April 11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |   |  |  |
| 23A. SIGNATURE Reuben C. Guerrero M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  |  | 23B. DATE SIGNED April 11, 1965   |  |  |
| 23C. PHYSICIAN'S NAME (Type) REUBEN C. GUERRERO  |  |  | 23D. ADDRESS MONTEBELLO STATE HOSPITAL  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL  |  | 24B. DATE 4/12/65  |   | 24C. NAME OF CEMETERY OR CREMATORY CHIZUK AMUNO (ARLINGTON)                  |  |
| 24D. LOCATION BALTIMORE  |  | 24E. STATE MARYLAND  |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 13 1965  |  | 25B. NAME OF REGISTRAR Robert E. Galt  |   | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD |  |

V.S. 153

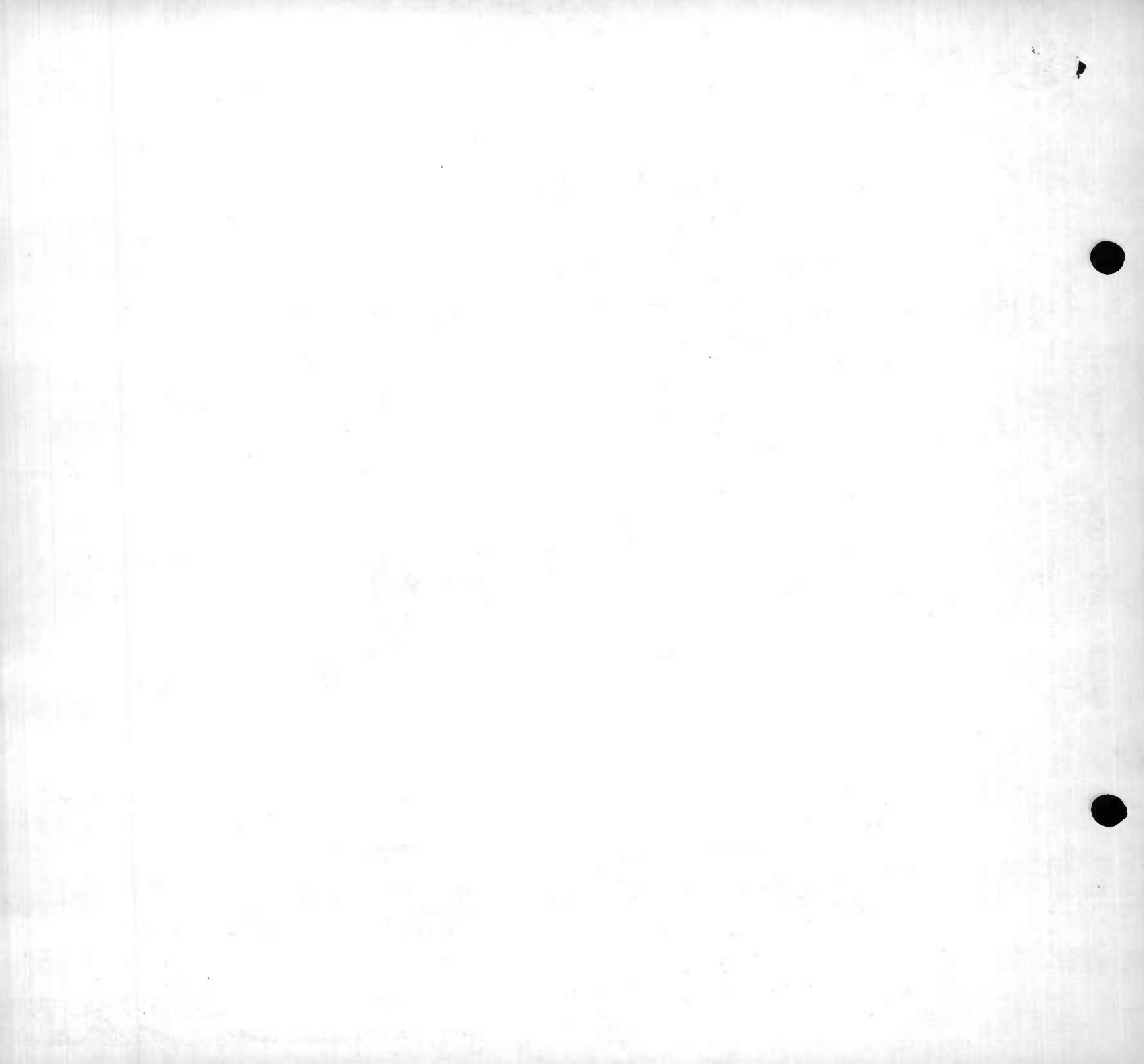
6-21-65

M.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3915   |                         |   |                  | BALTIMORE CITY HEALTH DEPARTMENT   |                            | Registered No. 65 3915   |  |
|---|-------------------------|---|------------------|--|----------------------------|--|--|
| M.E. CASE NO.   |                         |   |                  | CERTIFICATE OF DEATH   |                            |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Anne Silbermar</i>  |                         |   |                  | 2. DATE AND HOUR OF DEATH<br><i>Apr 11/65 755 P. M.</i>  |                            |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         |   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |                            |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Belvedere Nursing Home</i>  |                         |   |                  | A. STATE <i>Ind</i> B. COUNTY <i>27-17</i>   |                            |  |  |
|   |                         |   |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>  |                            |  |  |
|   |                         |   |                  | D. STREET ADDRESS (If rural, give location)<br><i>2525 W Belvedere Ave</i>   |                            |  |  |
| 5. SEX<br><i>Female</i>   | 6. RACE<br><i>White</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Widowed</i>                                | 8. DATE OF BIRTH | 9. AGE (In years last birthday)<br><i>73</i>   | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  |                  | 11. BIRTHPLACE (State or foreign country)<br><i>Balto, Ind</i>   |                            | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA.</i>                          |  |
| 13. FATHER'S NAME<br><i>Nathan Bromson</i>  |                         |   |                  | 14. MOTHER'S MAIDEN NAME<br><i>Henrietta</i>   |                            |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT<br><i>Alvin Austin</i>   |                            | ADDRESS<br><i>10 Sunny Lane West Port, Conn</i>                      |  |
| 18. <i>332X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>Pneumonia</i><br><i>Cerebral Thrombosis, prot. Rt Int. Carotid art</i> |                         |   |                  | (A) DUE TO   |                            | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 days</i>                    |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |                  | (B) DUE TO   |                            | <i>8 days</i>  |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  | 20A. AUTOPSY? (Yes or No)  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                  | 21F. HOW DID INJURY OCCUR?   |                            |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>March 1964</i> to <i>Apr. 11 1965</i> , that (I) (we) last saw the deceased alive on <i>Apr 4 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |                  |  |                            |  |  |
| 23A. SIGNATURE<br><i>James H. Cohen</i>   |                         |   |                  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                            | 23B. DATE SIGNED<br><i>4/12/65</i>                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>SONAS H. COHEN</i>   |                         |   |                  | 23D. ADDRESS<br><i>6702 Park Heights Ave.</i>  |                            |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial Personal</i>  |                         | 24B. DATE<br><i>4/13/65</i>   |                  | 24C. NAME OF CEMETERY OR CREMATORY<br><i>Mt Carmel</i>   |                            | 24D. LOCATION (City, town, or county) (State)<br><i>Queens N.Y.</i>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 13 1965</i>   |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |                  | 25C. FUNERAL DIRECTOR<br><i>Bob Thompson &amp; Bros</i>  |                            | ADDRESS<br><i>6010 West Rd. Balto, Md.</i>                           |  |

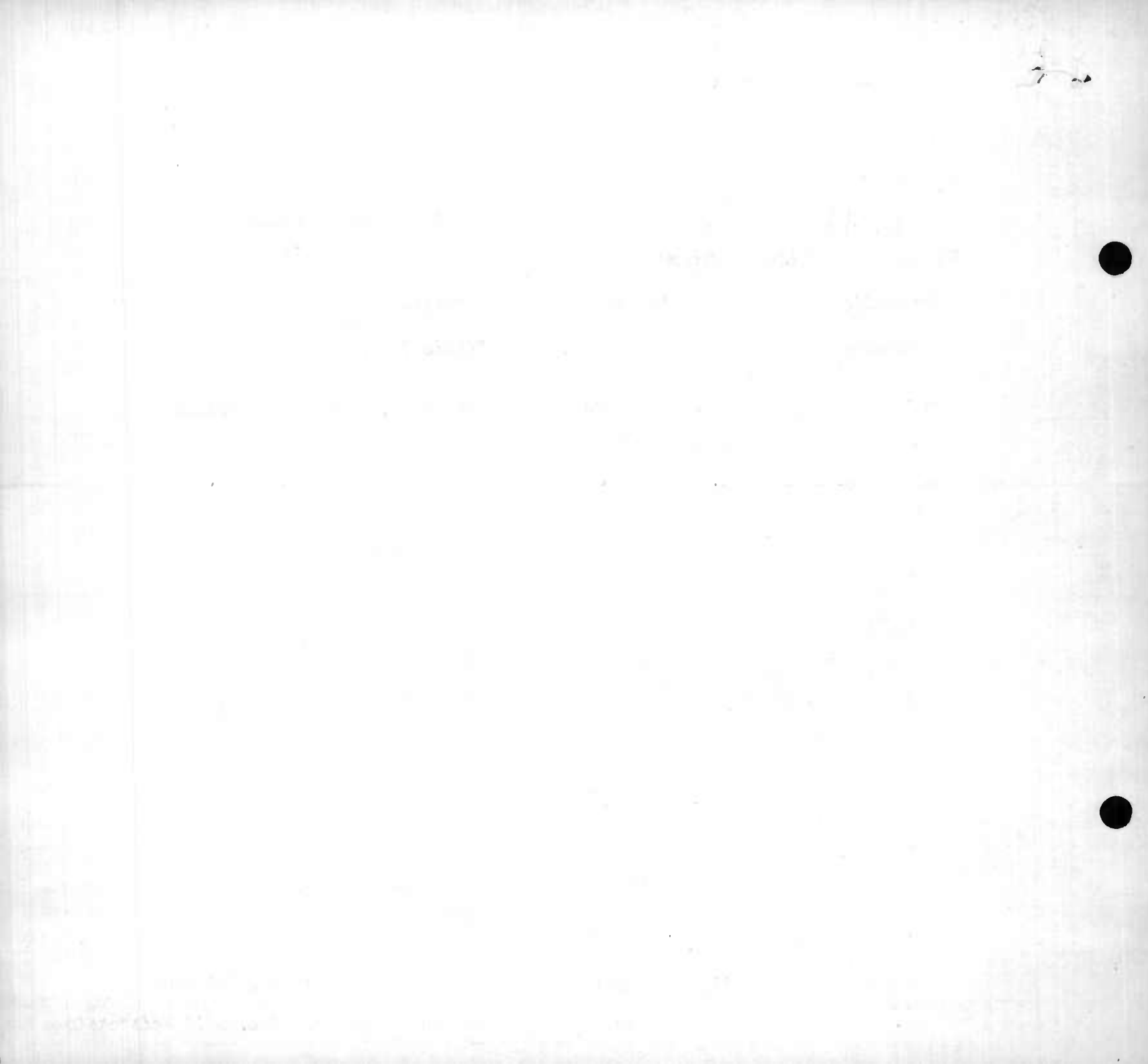




FUNERAL DIRECTOR: IMPORTANT

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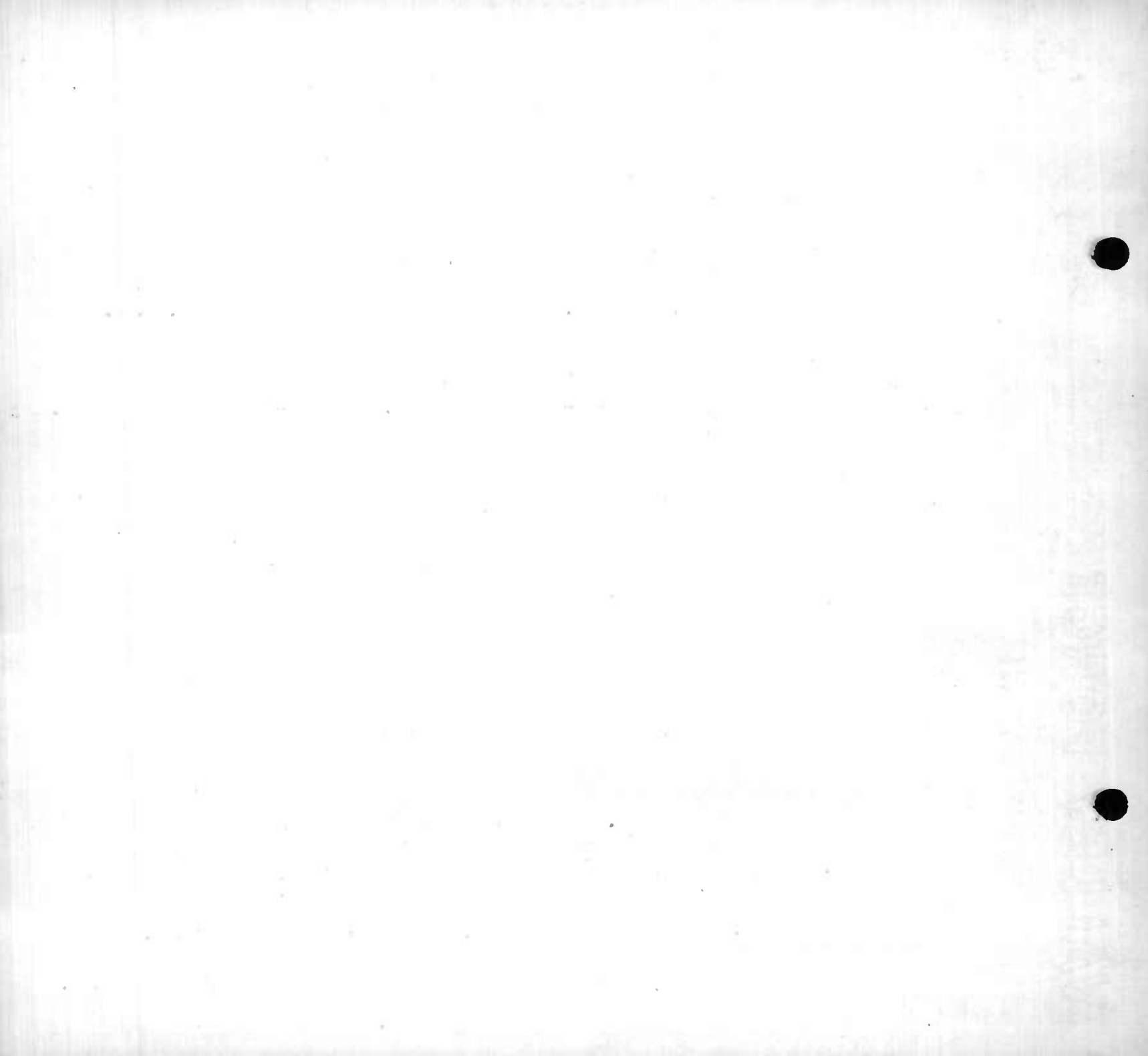
| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | BIRTH NO. 65 3916   |  | REGISTERED NO. 65 3916   |  |
|---|--|--|--|---|--|--|--|
| <b>CERTIFICATE OF DEATH</b>   |  |  |  | <b>1. NAME OF DECEASED</b><br>(Type or Print) <u>CENA FINE</u>  |  |  |  |
| <b>2. DATE AND HOUR OF DEATH</b><br><u>APRIL 10, 1965</u> <u>1 320</u> <u>1p</u> M.   |  |  |  | <b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>LEVINDALE, HEBREW HOME AND INFIRMARY</u> |  |  |  |
| <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>27-17</u>  |  | <b>5. SEX</b><br><u>Female</u>   |  | <b>6. RACE</b><br><u>White</u>  |  | <b>7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED</b> (specify)<br><u>Widow</u>      |  |
| <b>8. CITY OR TOWN</b> (If outside city limits, write RURAL and give township)<br><u>Baltimore</u>  |  | <b>9. DATE OF BIRTH</b><br><u>3004 Oakley Avenue</u>   |  | <b>10. AGE</b> (In years lost birthday)<br><u>78</u>  |  | <b>11. Under 1 Yr. Months: Days: Hours: Min.</b><br>If Under 24 Hrs. Min.          |  |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><u>Housewife</u>  |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><u>At Home</u>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><u>Russia</u>   |  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><u>USA</u>                                  |  |
| <b>13. FATHER'S NAME</b><br><u>Unknown</u>  |  |  |  | <b>14. MOTHER'S MAIDEN NAME</b><br><u>Tillie ?</u>  |  |  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  | <b>16. SOCIAL SECURITY NO.</b><br><u>No</u>  |  | <b>17. INFORMANT</b><br><u>Harry Fine, 2605 Oakley Avenue</u>   |  |  |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | <b>CAUSE OF DEATH</b><br>(A) <u>POSS. MYOCARDIAL INFARCTION</u><br>DUE TO<br>(B) <u>ARTERIO-SCLEROTIC CARDIO</u><br>DUE TO<br><u>VASC. DIS.</u><br>(C)  |  |  |  |
| <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><u>1 hour</u>  |  |  |  | <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>   |  |  |  |
| <b>19A. DATE OF OPERATION</b><br><u>0</u>   |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br><u>—</u>  |  | <b>20A. AUTOPSY?</b> (Yes or No)<br><u>No</u>   |  | <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>        |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br><input type="checkbox"/>  |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><u>—</u>      |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br><u>—</u>   |  |  |  |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)<br><u>—</u>  |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | <b>21F. HOW DID INJURY OCCUR?</b><br><u>—</u>   |  |  |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>JAN 8</u> <u>1963</u> <b>to</b> <u>APRIL 10</u> <u>1965</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>APRIL 10</u> <u>1965</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |  |  |  |   |  |  |  |
| <b>23A. SIGNATURE</b><br><u>M. R. Willner</u>   |  |  |  | <b>M.D. Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>   |  | <b>23B. DATE SIGNED</b><br><u>April 10, 1965</u>                                   |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><u>ROTH WILLNER</u>  |  |  |  | <b>23D. ADDRESS</b><br><u>LEVINDALE, HEBREW HOME AND INFIRMARY, BALTIMORE, MD.</u>  |  |  |  |
| <b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify)<br><u>Burial</u>   |  | <b>24B. DATE</b><br><u>April 11/65</u>   |  | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><u>Abavas Sholom</u>   |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><u>Baltimore, Maryland</u> |  |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><u>APR 13 1965</u>  |  | <b>25B. NAME OF REGISTRAR</b><br><u>Robert E. Oakley, Jr.</u>  |  | <b>25C. FUNERAL DIRECTOR</b><br><u>Sol Levinson &amp; Bros Inc. 6010 Reisterstown Rd</u>  |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3917   |                  |   |   | BALTIMORE CITY HEALTH DEPARTMENT  |   | Registered No. 65 3917   |  |  |  |  |
|---|------------------|---|---|---|---|--|--|--|--|--|
| M.E. CASE NO.   |                  |   |   | CERTIFICATE OF DEATH  |   |  |  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) Michael Rychlak  |                  |   |   | 2. DATE AND HOUR OF DEATH<br>April 11, 1965 7:55 p. M.  |   |  |  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>House In The Pines Nursing Home<br>5837 Belair Road  |                  |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY 1-04<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>2143 Cambridge Street |   |  |  |  |  |  |
| 5. SEX<br>Male  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married | 8. DATE OF BIRTH<br>Sept. 28, 1892  | 9. AGE (In years lost birthday)<br>72   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer |  |  |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Poland   |                  |   | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  |   |   | 13. FATHER'S NAME<br>Sebastian Rychlak                                   |  |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br>Anna Rychlak  |                  |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |   |   | 16. SOCIAL SECURITY NO.<br>213-09-4397                                   |  |  |  |  |
| 17. INFORMANT<br>Thaddeus M. Rychlak - 1031 Witherspoon Rd.   |                  |   | 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ACUTE CONGESTIVE HEART FAILURE<br>INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Stroke<br>10 days<br>Occlusion left Anterior Circulation<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |   |   | 19. DATE OF OPERATION<br>0   |  |  | 20. AUTOPSY? (Yes or No)<br>20A. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                  |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   |   | 21F. HOW DID INJURY OCCUR?   |  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4/10 1965 to 4/11 1965, that (I) (we) last saw the deceased alive on 4/11 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |   |   |   |   |  |  |  |  |  |
| 23A. SIGNATURE<br>Albert B. Bradley   |                  |   |   | 23B. DATE SIGNED<br>4/12/65   |   | 23C. PHYSICIAN'S NAME (Type)<br>Albert B. Bradley                        |  |  |  |  |
| 23D. ADDRESS<br>M.D. 4900 Belair Road Baltimore, Md.  |                  |   |   | 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |   |  |  |  |  |  |
| 24B. DATE<br>4/14/65  |                  | 24C. NAME OF CEMETERY OR CREMATORY<br>St. Stanislaus Cemetery       |   | 24D. LOCATION (City, town, or county) (State)<br>6515 Boston St. Baltimore, Md.   |   |  |  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 13 1965  |                  | 25B. NAME OF REGISTRAR<br>George A. Weber                           |   | 25C. FUNERAL DIRECTOR<br>George A. Weber 705 South Ann Street   |   |  |  |  |  |  |

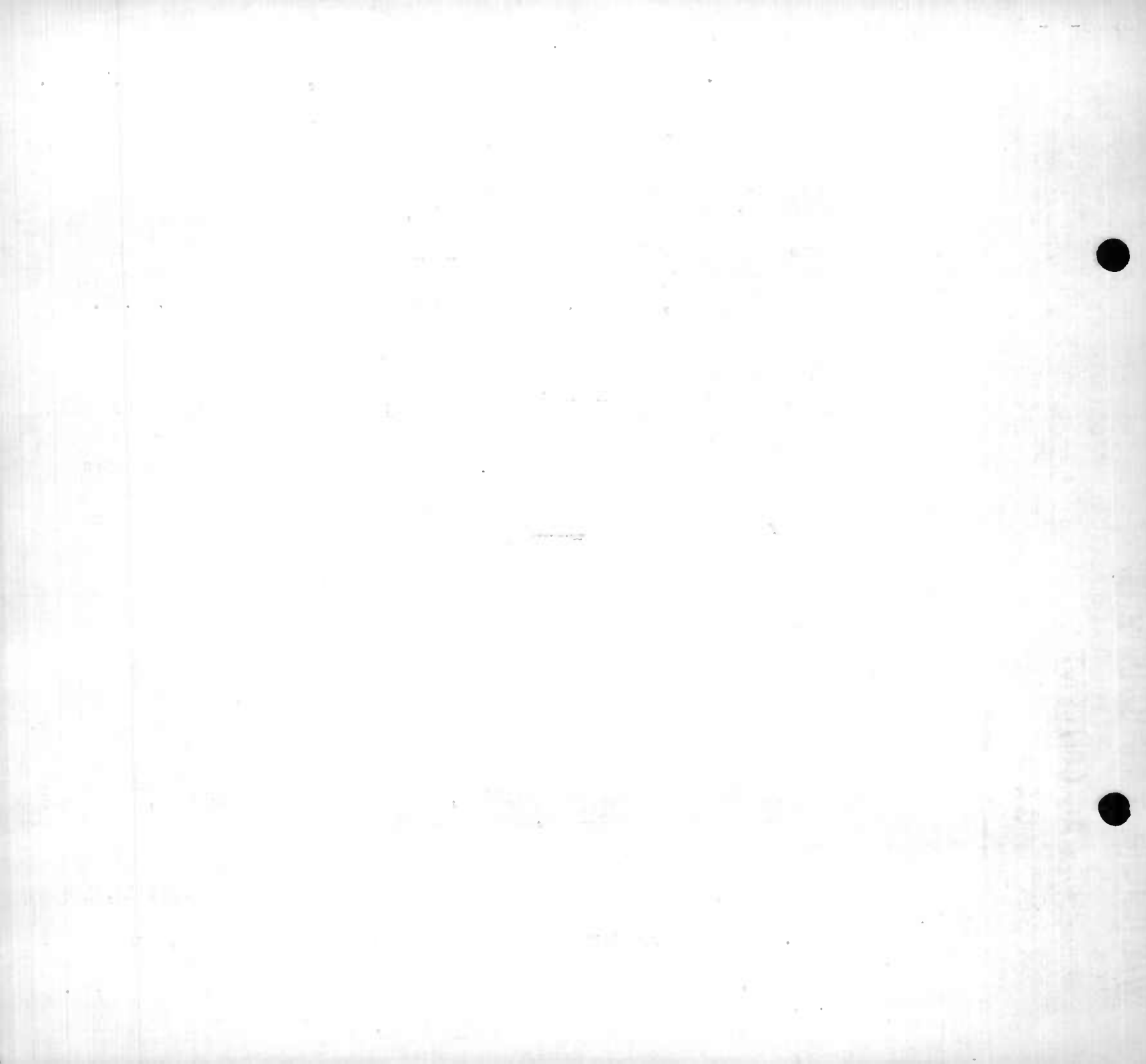


IS: 43-17-53

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

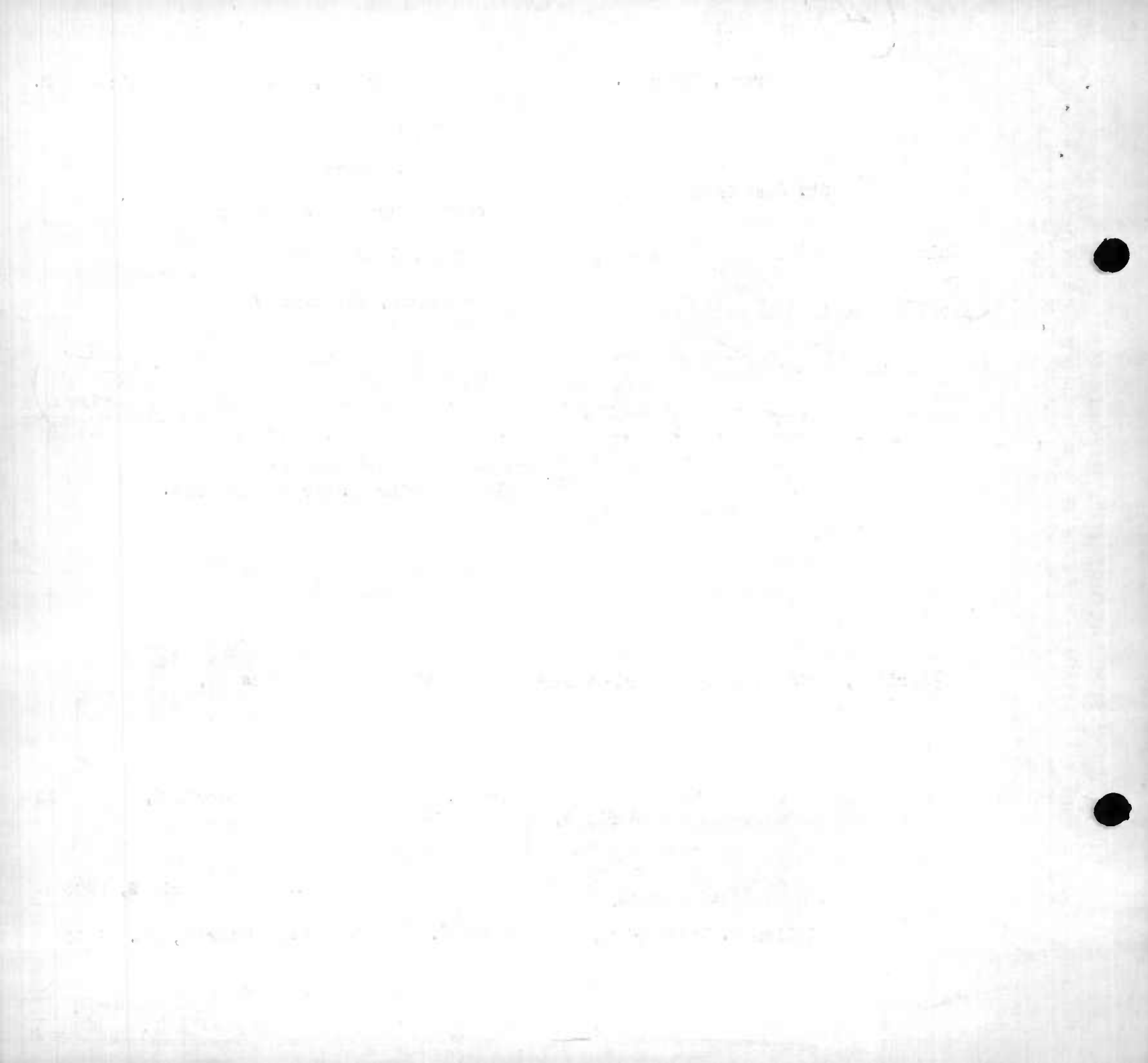
|  |                      |   |   |   |   |
|--|----------------------|---|---|---|---|
| BIRTH NO.<br>65 3918   |                      | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |   | Registered No. 65 3918  |   |
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print)<br>Frank L. Koenig   |                      |   | 2. DATE AND HOUR OF DEATH<br>April 12, 1965 6:00 A. M.  |   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224  |                      |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY 1-02<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore<br>D. STREET ADDRESS (If rural, give location)<br>617 S. Ellwood Avenue #21224 |   |   |
| 5. SEX<br>Male   | 6. RACE<br>White     | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (Specify)<br>Married                                       | 8. DATE OF BIRTH<br>3-12-10   | 9. AGE (In years last birthday)<br>55   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Maintenance Man   |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br>Beth, Steel Co.  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |   | 12. CITIZEN OF WHAT COUNTRY?<br>U. S. A.                                    |
| 13. FATHER'S NAME<br>Theodore Koenig   |                      |   | 14. MOTHER'S MAIDEN NAME<br>Elizabeth Roth  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |                      | 16. SOCIAL SECURITY NO.<br>215-09-8792  | 17. INFORMANT ADDRESS<br>RECORDS: BCH: 4940 Eastern Avenue #21224   |   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      |   | CAUSE OF DEATH<br>(A) Respiratory Arrest<br>DUE TO<br>(B) Metastatic Spread Squamous Cell<br>Carcinoma<br>(C)   |   | INTERVAL BETWEEN ONSET AND DEATH<br>Minutes<br>Months                       |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                      |   |   |   |   |
| 19A. DATE OF OPERATION<br>2  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br>Yes  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>Yes |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)        |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from April 8, 19 65 to April 12, 19 65, that (I) (we) last saw the deceased alive on April 12, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.               |                      |   |   |   |   |
| 23A. SIGNATURE<br><i>Dr. Charles Carpenter</i>   |                      |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |   | 23B. DATE SIGNED<br>April 12, 1965  |
| 23C. PHYSICIAN'S NAME (Type)<br>Dr. Charles Carpenter  |                      |   | 23D. ADDRESS<br>M.D. 4940 Eastern Avenue Baltimore, Maryland #24  |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   | 24B. DATE<br>4/14/65 | 24C. NAME OF CEMETERY or CREMATORY<br>Most Holy Redeemer Cemetery   |   | 24D. LOCATION (City, town, or county) (State)<br>4430 Belair Rd, Baltimore, Md. |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 13 1965   |                      | 25B. NAME OF REGISTRAR<br>Robert E. [unclear]   |   | 25C. FUNERAL DIRECTOR<br>George A. Weber 705 South Ann Street                   |   |



# FUNERAL DIRECTOR: IMPORTANT

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|   |                         |  |   |  |  |
|---|-------------------------|--|---|--|--|
| BIRTH NO. <b>65 3919</b>  |                         | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. <b>65 3919</b>  |  |
| M.E. CASE NO.   |                         | CERTIFICATE OF DEATH   |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                         | 2. DATE AND HOUR OF DEATH  |   |  |  |
| <b>Shreck, Harry E.</b>   |                         | <b>April 9, 1965</b>   |   | <b>12:10 P.M.</b>  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>St. Joseph Hospital</b>  |                         | A. STATE <b>Maryland</b><br>B. COUNTY <b>15-38</b>   |   |  |  |
| (If not in hospital or institution, give street address or location)  |                         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 21216</b>                                    |   |  |  |
|   |                         | D. STREET ADDRESS (If rural, give location)<br><b>3506 Gwynns Falls Parkway</b>  |   |  |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>   | 8. DATE OF BIRTH<br><b>May 16, 1905</b> | 9. AGE (In years last birthday)<br><b>59</b>                                       | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Interior Decorator, Gen. Business</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>            |  |
| 13. FATHER'S NAME<br><b>Harry Shreck</b>  |                         | 14. MOTHER'S MAIDEN NAME<br><b>Margaret Turner</b>   |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.<br><b>212-44-5036</b>  |   | 17. INFORMANT ADDRESS<br><b>Mrs. Veronica Shreck (Same)</b>                        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Streptococcus peritonitis; old posterior myocardial infarct.</b>   |                         | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         | (B) DUE TO   |   |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         | (C)  |   |  |  |
| MEDICAL CERTIFICATION   |                         |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>April 8, 1965</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Bleeding gastric ulcer</b>  |   | 20A. AUTOPSY? (Yes or No)<br><b>yes</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b> |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)           |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>March 9, 1965</b> to <b>April 9, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 9, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |   |  |  |
| 23A. SIGNATURE<br><b>William B. VandeGrift</b>  |                         | M.D. Attending Phys. <input type="checkbox"/> Mod. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED<br><b>April 9, 1965</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>William B. VandeGrift,</b>   |                         | 23D. ADDRESS<br><b>M.D. 1400 N. Caroline St., Baltimore, Md. 21213</b>   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4/13/65</b>  |   | 24C. NAME of CEMETERY or CREMATORY<br><b>London St. Bldg.</b>                      |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |                         |  |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Jackson</b>   |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>1312 N. 4101 Edmondson</b>                     |  |

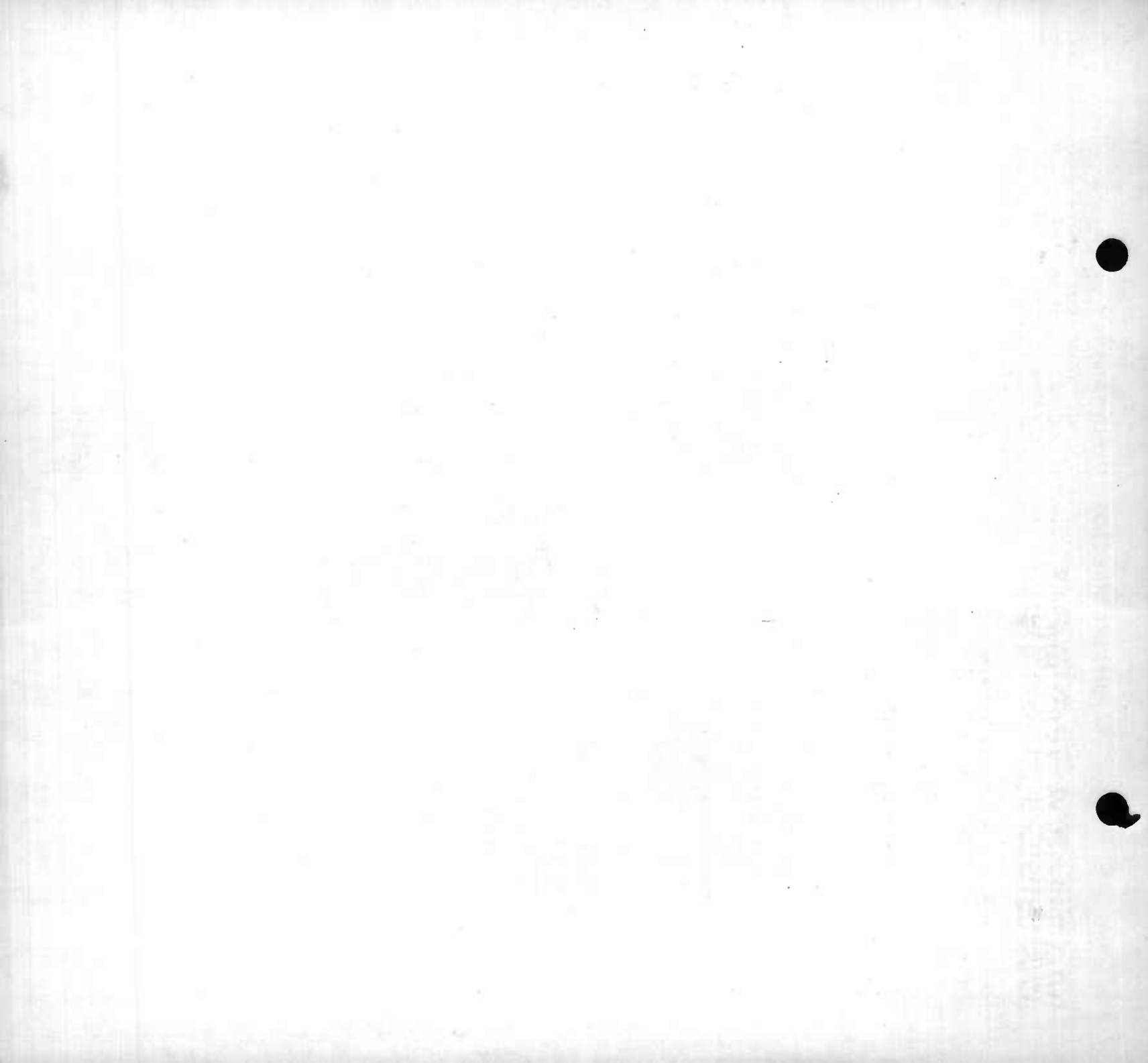




# FUNERAL DIRECTOR: IMPORTANT

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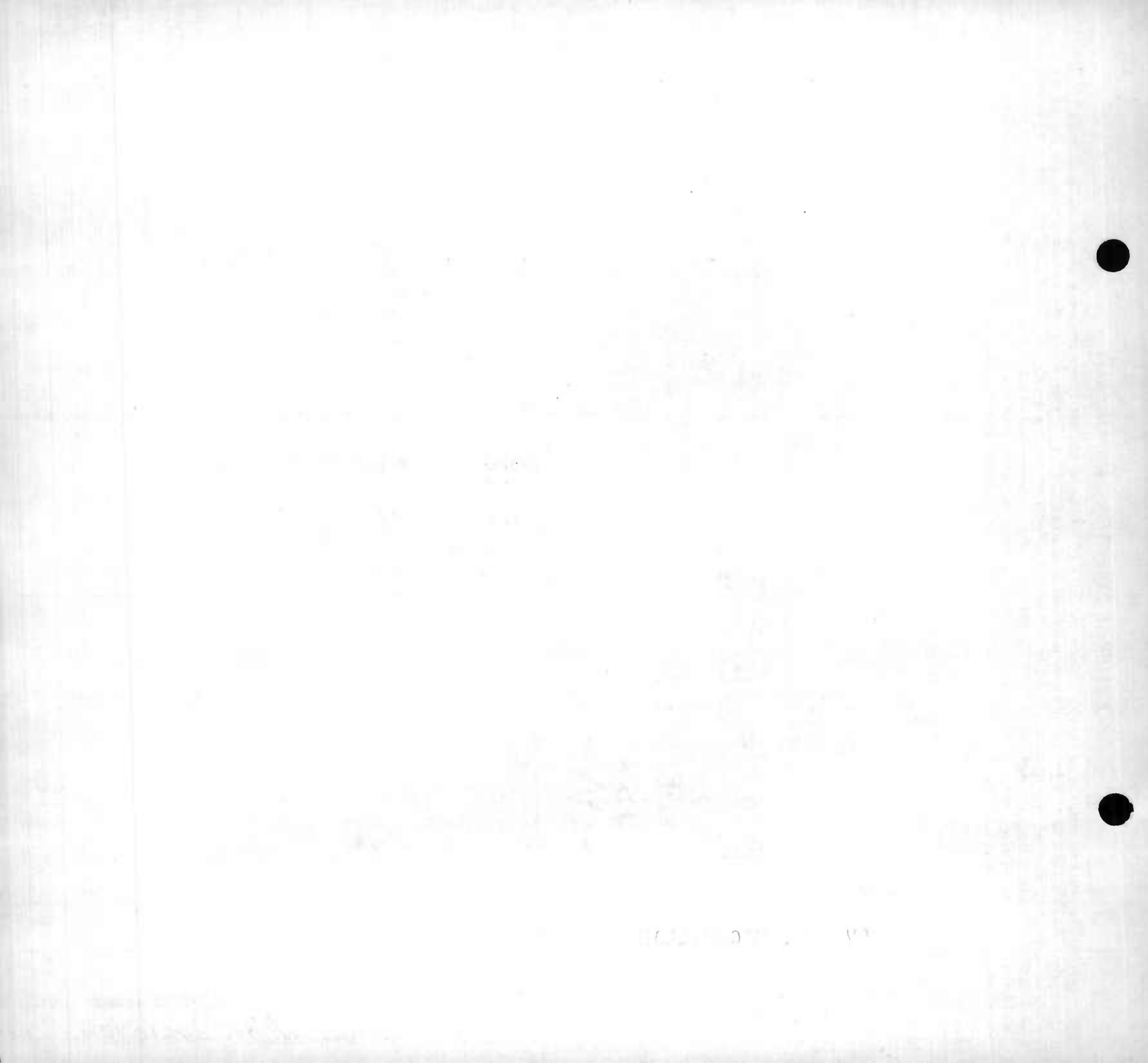
| Baltimore City Health Department   |  |  |  | Registered No.                                |  |
|--|--|--|--|---|--|
| BIRTH NO.  |  | 65 3920  |  | 65 3920                                       |  |
| M.E. CASE NO.  |  |  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  |   |  |
| WALTER STOCKHAUSEN   |  | APRIL 12 1965 1:15 P.M.  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)   |  | A. STATE B. COUNTY   |  |   |  |
| UNION Memorial Hospital<br>BALTIMORE, MARYLAND   |  | MARYLAND 8-11  |  |   |  |
|  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |  |   |  |
|  |  | BALTIMORE  |  |   |  |
|  |  | D. STREET ADDRESS (If rural, give location)  |  |   |  |
|  |  | 3117 LAWVIEW AVENUE  |  |   |  |
| 5. SEX   | 6. RACE  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH   | 9. AGE (In years lost birthday)               | 10. If Under 1 Yr. Months: Days: Hours: Min. |
| MALE   | CAUCASIAN  | MARRIED  | 8/27/84  | 80  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)     |  |
| RETIRED Police   |  | Beth-Stud  |  | BALTIMORE, MARYLAND                           |  |
| 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  | 12. CITIZEN OF WHAT COUNTRY?                  |  |
| EMIL STOCKHAUSEN   |  | -  |  | UNITED STATES                                 |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS                         |  |
|  |  |  |  | Mrs. Anna Stockhausen 3117 Lawview            |  |
| 18. 002.1 I  |  | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH              |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | (A) Lobar pneumonia  |  | 24 hr.  |  |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |  | (B) Active tuberculosis  |  | 30 yr. (?)                                    |  |
| ANTECEDENT CAUSES  |  | (C) Myocardial infarction  |  | 724 hr.                                       |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | Lung abscess - left.   |  | ?   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |   |  |
| 19A. DATE OF OPERATION   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 2  |  | YES  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
|  |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)  | 21E. INJURY OCCURRED   | 21F. HOW DID INJURY OCCUR?   |  |   |  |
|  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 12 19 65 to April 12 19 65, that (I) (we) last saw the deceased alive on April 12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED                              |  |
| David M. Mac Millan  |  |  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS   |  |   |  |
| David M. Mac Millan  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   | 24B. DATE  | 24C. NAME OF CEMETERY or CREMATORY   |  | 24D. LOCATION (City, town, or county) (State) |  |
| Burial   | 4/15/65  | Landon Park  |  | Baltimore                                     |  |
| 25A. DATE REC'D BY HEALTH DEPT.  | 25B. NAME OF REGISTRAR   | 25C. FUNERAL DIRECTOR  |  | ADDRESS                                       |  |
| APR 13 1965  | Robert E. Taylor   | 3117 Lawview Ave.  |  | J.N.N.  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3921  |                             |   |   | BALTIMORE CITY HEALTH DEPARTMENT  |                                     | Registered No. 65 3921   |  |
|--|-----------------------------|---|---|---|-------------------------------------|--|--|
| M.E. CASE NO.  |                             |   |   | 1. NAME OF DECEASED<br>(Type or Print) <b>CARRIE E. NAGLE</b>   |                                     |  |  |
| 2. DATE AND HOUR OF DEATH<br><b>April 12, 1965 12:01 A.M.</b>  |                             |   |   |   |                                     |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>411 UNION Memorial Hospital<br/>BALTIMORE, Maryland</b>  |                             |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2702</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b><br>D. STREET ADDRESS (If rural, give location)<br><b>4500 ARABIA AVENUE</b> |                                     |  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                                | 8. DATE OF BIRTH<br><b>5/27/88</b>  | 9. AGE (In years lost birthday)<br><b>76</b>  | If Under 1 Yr. Months: Days:        | If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br>—  |   | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>                 |  |
| 13. FATHER'S NAME<br><b>FREDERICK KRUMREIN</b>   |                             |   | 14. MOTHER'S MAIDEN NAME<br><b>Augusta J. Hunter</b>  |   |                                     |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                             |   | 16. SOCIAL SECURITY NO.<br><b>216-32-9628</b>   |   | 17. INFORMANT<br><b>Ma A Strata</b> |  |  |
| 18. <b>153.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphemia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.      |                             |   | CAUSE OF DEATH<br>(A) <b>PERFORATED ULCER</b><br>DUE TO<br>(B) <b>CARCINOMA OF Cecum</b><br>DUE TO<br>(C) — |   |                                     | INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| MEDICAL CERTIFICATION  |                             |   |   |   |                                     |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                             |   |   |   |                                     |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |                                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                     |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |                                     |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 2</b> 19 <b>65</b> to <b>April 12</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 11</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |   |   |   |                                     |  |  |
| 23A. SIGNATURE<br><b>David M. Mac Millan</b>   |                             |   |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                                     | 23B. DATE SIGNED<br><b>4/12/65</b>                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DAVID M. MAC MILLAN</b>   |                             |   |   | 23D. ADDRESS<br>M.D.  |                                     |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                             | 24B. DATE<br><b>April 15/65</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Landon Park</b>  |                                     | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore</b>    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Stachurski</b>   |   | 25C. FUNERAL DIRECTOR<br><b>W. B. Funeral Home</b>  |                                     | ADDRESS<br><b>4210 Belair Rd</b>                                     |  |



BIRTH NO. 65 3922 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RODELL BAILEY

2. DATE AND HOUR PRONOUNCED DEAD

4-12-65

1:10 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

PROVIDENT HOSPITAL

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1732 N. Dallas Street 21213

5. SEX

Male

6. RACE

Colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)  
Never married

8. DATE OF BIRTH

Aug. 15, 1936

9. AGE (In years  
last birthday)

28

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Laborer

10B. KIND OF BUSINESS OR INDUSTRY

Laborer

11. BIRTHPLACE (State or foreign country)

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Ralph Bailey

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or doles of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

Mrs. Beulah Francis 1732 N. Dallas St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)(A) Hemothorax  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Stab wound of back  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)  
Street21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?

In front of 1536 N. Fulton Ave.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 12 '65 AM

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Stabbed in back with butcher knife

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

PETER W. RIECKERT, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4-12-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

April 15, '65

23C. NAME of CEMETERY or CREMATORY

Mt. 61 Calvary

23D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

24B. NAME OF REGISTRAR

Robert E. Fagundes

24C. FUNERAL DIRECTOR

Marshall W. Jones, Jr. Funeral Home  
1735 Harford Avenue

ADDRESS

WITNESSES

April 15, 1936

Lower Harbor

Baltimore, Maryland

Laborer

Laborer

Reino Bailey

Mrs. Gordon Thomas 1712 N. Dallas St.

to

WITNESSES

Baltimore, Maryland

April 15, 1936

Witness

Charles M. Jones, Jr. General Agent  
1335 Lombard Avenue

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |  |   |  |  |   |  |  |  |                              |  |  |  |
|--|--|--|--|--|---|--|--|---|--|--|--|------------------------------|--|--|--|
| BIRTH NO.  |  |  |  |  | CERTIFICATE OF DEATH  |  |  |   |  | Registered No.                                 |  |                              |  |  |  |
| 65 3923  |  |  |  |  |   |  |  |   |  | 65 3923  |  |                              |  |  |  |
| M.E. CASE NO.  |  |  |  |  | 1. NAME OF DECEASED   |  |  |   |  | 2. DATE AND HOUR OF DEATH                      |  |                              |  |  |  |
|  |  |  |  |  | LEVINSON, SAUL  |  |  |   |  | April 11, 1965 11 45 A.M.                      |  |                              |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |   |  |  |  |                              |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |  |  |  |  | A. STATE  |  |  |   |  | B. COUNTY                                      |  |                              |  |  |  |
| SINAI HOSPITAL OF BALTIMORE  |  |  |  |  | Baltimore, County   |  |  |   |  |  |  |                              |  |  |  |
|  |  |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |  |   |  | Owings Mills Md. 3300                          |  |                              |  |  |  |
|  |  |  |  |  | D. STREET ADDRESS (If rural, give location)   |  |  |   |  | CAVES Road.                                    |  |                              |  |  |  |
| 5. SEX   |  | 6. RACE  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                   |   | 8. DATE OF BIRTH   |  | 9. AGE (In years last birthday)           |  | If Under 1 Yr. Months: Days                    |  | If Under 24 Hrs. Hours: Min. |  |  |  |
| Male   |  | White  |  | Married  |   | 2/12/75  |  | 91  |  |  |  |                              |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |   |  |  | 11. BIRTHPLACE (State or foreign country) |  |  |  | 12. CITIZEN OF WHAT COUNTRY? |  |  |  |
| Ret  |  |  |  | JEWELER  |   |  |  | POLAND                                    |  |  |  | UNITED STATES                |  |  |  |
| 13. FATHER'S NAME  |  |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |   |  |  |  |                              |  |  |  |
| ISAAC  |  |  |  |  | ZECIL   |  |  |   |  |  |  |                              |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |   |  | 17. INFORMANT                                  |  |                              |  |  |  |
| NO   |  |  |  |  | 217-32-9824   |  |  |   |  | MRS. NATHAN LAYTON                             |  |                              |  |  |  |
|  |  |  |  |  |   |  |  |   |  | ADDRESS OWINGS MILLS, MD CAVES ROAD            |  |                              |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  |  |  |  | CAUSE OF DEATH  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH               |  |                              |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)   |  |  |  |  | (A) DUE TO  |  |  |   |  | CARCINOMA of the Pancreas ~ 4 mos. (suspected) |  |                              |  |  |  |
| ANTECEDENT CAUSES  |  |  |  |  | (B) DUE TO  |  |  |   |  |  |  |                              |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |  |  |  | (C) DUE TO  |  |  |   |  |  |  |                              |  |  |  |
| II   |  |  |  |  | I- CORONARY HEART DISEASE   |  |  |   |  |  |  |                              |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |  |   |  |  |   |  |  |  |                              |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |  |  |                              |  |  |  |
|  |  |  |  |  |   |  |  |   |  |  |  |                              |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |  |  |   |  |  |  |                              |  |  |  |
|  |  |  |  |  |   |  |  |   |  |  |  |                              |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |   |  |  |   |  |  |  |                              |  |  |  |
|  |  |  |  |  |   |  |  |   |  |  |  |                              |  |  |  |
| 22. I certify that (this hospital) attended the deceased from March 30, 1965 to April 11, 1965, that (we) lost saw the deceased alive on April 11, 1965 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (view) the body after death. |  |  |  |  |   |  |  |   |  |  |  |                              |  |  |  |
| 23A. SIGNATURE   |  |  |  |  | 23B. DATE SIGNED  |  |  |   |  |  |  |                              |  |  |  |
| Benjamin Robert Chipman M.D.   |  |  |  |  | April 11, 1965  |  |  |   |  |  |  |                              |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |  |  |  | 23D. ADDRESS  |  |  |   |  |  |  |                              |  |  |  |
| Benjamin Robert Chipman M.D.   |  |  |  |  | Sinai Hospital  |  |  |   |  |  |  |                              |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (specify)   |  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY                                       |   | 24D. LOCATION (City, town, or county) (State)                        |  |   |  |  |  |                              |  |  |  |
| Burial   |  | 4/12/65  |  | Hebrew Young Men   |   | Balto Md   |  |   |  |  |  |                              |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |   | ADDRESS  |  |   |  |  |  |                              |  |  |  |
| APR 13 1965  |  | Robert E. Farber M.D.  |  | Sydney S. Levinson INC   |   | 3319 Olympia ave   |  |   |  |  |  |                              |  |  |  |



11 12

April 11, 1902

Dear Mr. [illegible]

Enclosed for you

are the [illegible]

and [illegible]

which I have [illegible]

to [illegible]

and [illegible]

Very [illegible]

[illegible]

Yours [illegible]

Very [illegible]

Very [illegible]

Very [illegible]

Very [illegible]

[illegible]

[illegible]



# FUNERAL DIRECTOR: IMPORTANT

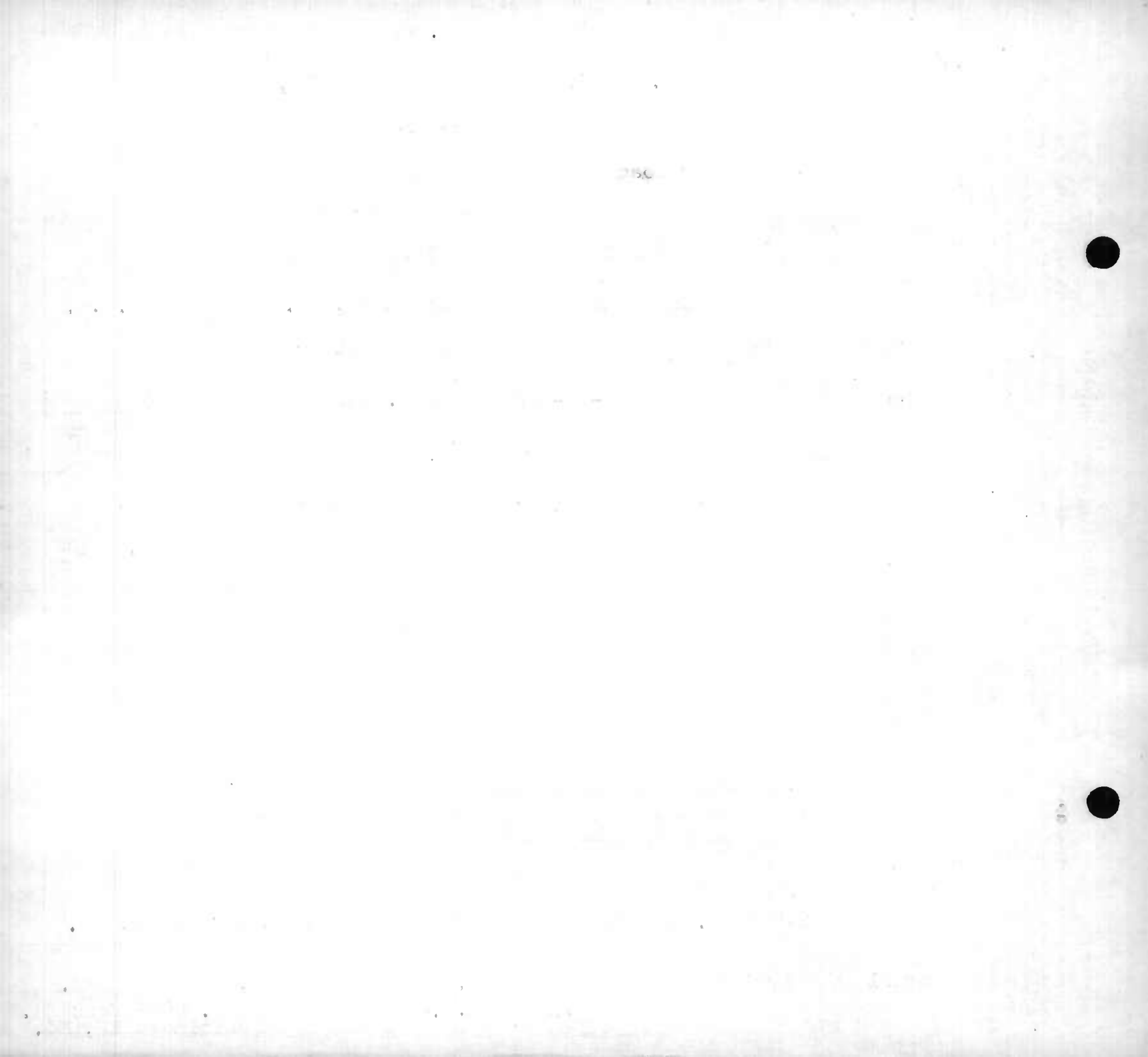
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3924   |                     |  |                                   | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3924   |  |
|---|---------------------|--|-----------------------------------|--|---|--|--|
| M.E. CASE NO.   |                     |  |                                   | 1. NAME OF DECEASED<br>(Type or Print) <b>KATHRYN ELIZABETH REITZ</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>4-11-65 7 55 P.M.</b>                            |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                     |  |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |                     | (If not in hospital or institution, give street address or location)                                 |                                   | A. STATE <b>MARYLAND</b>   |   | B. COUNTY <b>2712</b>  |  |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b>   |                     |  |                                   | D. STREET ADDRESS (If rural, give location)<br><b>3 BRACKENRIDGE COURT</b>   |   |  |  |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Single</b>                              | 8. DATE OF BIRTH<br><b>8-2-17</b> | 9. AGE (In years last birthday)<br><b>47</b>   | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Teacher</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Free Education</b>   |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                       |  |
| 13. FATHER'S NAME<br><b>EMIL G. REITZ</b>   |                     |  |                                   | 14. MOTHER'S MAIDEN NAME<br><b>ELIZA ANN Shipley</b>   |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                     | 16. SOCIAL SECURITY NO.<br><b>314-03-2875</b>  |                                   | 17. INFORMANT ADDRESS<br><b>CHART - Union Memorial Hosp.</b>   |   |  |  |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Metastatic carcinoma of the ovary</b>  |                     |  |                                   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 yr.</b>   |   |  |  |
| II. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                     |  |                                   |  |   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |  |                                   |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>0 -</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |                                   | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>-</b> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b> |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>-</b>   |   |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)<br><b>-</b>   |                     | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work At Work <input type="checkbox"/>         |                                   | 21F. HOW DID INJURY OCCUR?<br><b>-</b>   |   |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>4-10-1965</b> to <b>4-11-1965</b> , that (2) (we) last saw the deceased alive on <b>4-11-1965</b> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |  |                                   |  |   |  |  |
| 23A. SIGNATURE<br><b>Lawrence J. Lieberman</b>  |                     |  |                                   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED<br><b>4-11-65</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>LAWRENCE J. LIEBERMAN</b>  |                     |  |                                   | 23D. ADDRESS<br><b>Union Memorial Hosp., Balto., Md.</b>   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>4/14/1965</b>  |                                   | 24C. NAME of CEMETERY or CREMATORY<br><b>New Cathedral Cem.</b>  |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>           |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                     | 25B. NAME OF REGISTRAR<br><b>Al H. E. Felt</b>   |                                   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>H. W. Jenkins &amp; Sons Co. 4905 York Road Baltimore 12, Md.</b>                                |   |  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3925   |                     |  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | CERTIFICATE OF DEATH  |   | Registered No. 65 3925   |  |
|---|---------------------|--|--|---|--|---|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Bessie E. Smith</b>   |                     |  |  | 2. DATE AND HOUR OF DEATH<br><b>April 11, 1965 8:05 A.M.</b>  |  |   |   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>1028 Woodson Road.</b>  |                     |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>27-48</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1028 Woodson Road</b> |  |   |   |  |  |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Married</b> | 8. DATE OF BIRTH<br><b>7/27/1906</b>   | 9. AGE (In years last birthday)<br><b>58</b>  | If Under 1 Yr. Months: Days: Hours: Min.                           |   | If Under 24 Hrs. Min.                         |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                     |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |  |
| 13. FATHER'S NAME<br><b>William Meseke</b>  |                     |  | 14. MOTHER'S MAIDEN NAME<br><b>Bertha Ellmer</b>   |   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b> |   |  |  |
| 16. SOCIAL SECURITY NO.<br><b>215-22-0720</b>   |                     |  | 17. INFORMANT<br><b>Harry H. Smith</b>   |   |  | ADDRESS<br><b>(Same)</b>  |   |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Chronic glomerulonephritis</b>   |                     |  | CAUSE OF DEATH<br>(A) <b>Chronic glomerulonephritis</b><br>(B) <b>Chronic myocarditis</b><br>(C) <b>Hypertensive C-V disease</b>     |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>10 yrs</b>   |   |  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Terminal uremia</b>  |                     |  | 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH <del>REL</del> RELATED TO THE DISEASE OR CONDITION CAUSING IT.            |   |  |   |   |  |  |
| 21A. DATE OF OPERATION<br><b>0</b>  |                     |  | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |  | 21C. AUTOPSY? (Yes or No)   |   | 21D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     |  | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                    |   |  | 21F. HOW DID INJURY OCCUR?  |   |  |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Dec 16, 1964</b> to <b>April 11, 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>April 10, 1965</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |                     |  |  |   |  |   |   |  |  |
| 23A. SIGNATURE<br><b>H.V. Harbold</b>   |                     |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |   |  | 23B. DATE SIGNED<br><b>April 13, 1965</b>   |   |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Harold V. Harbold</b>  |                     |  | 23D. ADDRESS<br><b>4706 Harford Road, Baltimore, Md.</b>   |   |  |   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     |  | 24B. DATE<br><b>4/14/1965</b>  |   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Loudon Park Cem.</b>   |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                     |  | 25B. NAME OF REGISTRAR<br><b>W. Jenkins</b>  |   |  | 25C. FUNERAL DIRECTOR<br><b>H.W. Jenkins &amp; Sons Co. 4905 York Rd. Baltimore 12, Md.</b>                           |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

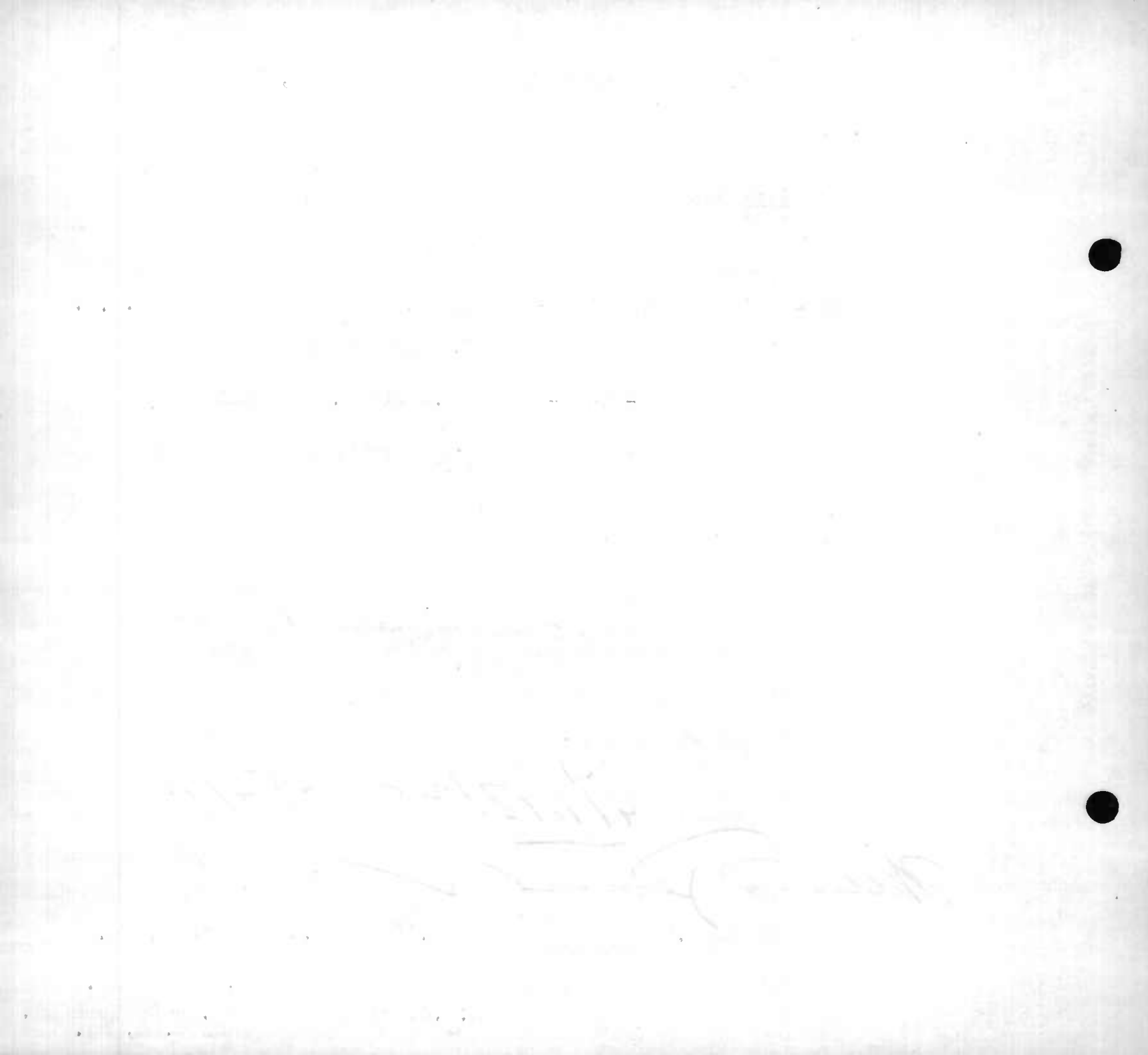
| BALTIMORE CITY HEALTH DEPARTMENT   |           |  |                         | Registered No. 65 3926   |  |
|--|-----------|--|-------------------------|--|--|
| BIRTH NO. 65 3926  |           | CERTIFICATE OF DEATH   |                         |  |  |
| M.E. CASE NO.  |           | 1. NAME OF DECEASED (Type or Print) Hinton, Jerome L. (JERRY)  |                         | 2. DATE AND HOUR OF DEATH 4-11-65 6 <sup>30</sup> AM                                 |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |           | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                  |                         |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 34 Bon Secours Hospital  |           | A. STATE B. COUNTY Baltimore Md. 9-02  |                         |  |  |
|  |           | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore                      |                         |  |  |
|  |           | D. STREET ADDRESS (If rural, give location) 1517 Oakridge Rd - 18                                      |                         |  |  |
| 5. SEX M   | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED   | 8. DATE OF BIRTH 5-6-05 | 9. AGE (If years lost birthday) 59   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN   |           | 10B. KIND OF BUSINESS OR INDUSTRY DRY CLEANER  |                         | 11. BIRTHPLACE (State or foreign country) MARYLAND                                   |  |
| 13. FATHER'S NAME Lemuel Hinton  |           | 14. MOTHER'S MAIDEN NAME Virginia Clark  |                         | 12. CITIZEN OF WHAT COUNTRY? USA   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No  |           | 16. SOCIAL SECURITY NO. 216-034363   |                         | 17. INFORMANT ADDRESS FLORENCE H. HINTON (SAME)                                      |  |
| 18. 420.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |           | CAUSE OF DEATH   |                         | INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  |           | (A) Acute Myocardial Infarction DUE TO   |                         |  |  |
|  |           | (B) Hemopericardium DUE TO   |                         |  |  |
|  |           | (C) Acute Heart Failure  |                         |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |           |  |                         |  |  |
| 19A. DATE OF OPERATION 2   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                         | 20A. AUTOPSY? (Yes or No) Yes  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)             |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                         | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased, from 4-10-1965 to 4-11-1965, that (I) (we) last saw the deceased alive on 4-11-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |           |  |                         |  |  |
| 23A. SIGNATURE Cristin Linantud, Jr. M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |           |  |                         | 23B. DATE SIGNED 4-11-65   |  |
| 23C. PHYSICIAN'S NAME (Type) Cristin Linantud, M.D.  |           |  |                         | 23D. ADDRESS Bon Secours Hosp.   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |           | 24B. DATE 4/14/1965  |                         | 24C. NAME OF CEMETERY or CREMATORY Moreland Memorial Park Parkville, Balto. Co., Md. |  |
| 24D. LOCATION  |           | 24E. CITY, town, or county Baltimore 12, Md.   |                         | 24F. STATE   |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 13 1965  |           | 25B. NAME OF REGISTRAR   |                         | 25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Baltimore 12, Md.       |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |              |  |   | 65 3927   |   | 65 3927  |  |
|---|--------------|--|---|---|---|--|--|
| BIRTH NO.   |              |  |   | CERTIFICATE OF DEATH  |   |  |  |
| M.E. CASE NO.   |              |  |   | Registered No.  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |              |  |   | 2. DATE AND HOUR OF DEATH   |   |  |  |
| Oswald Roddy Hardwell   |              |  |   | April 11, 1965  |   | 8 <sup>30</sup> P M.   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |              |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>Gaddis Nursing Home   |              |  |   | A. STATE<br>Maryland  |   |  |  |
| (If not in hospital or institution, give street address or location)  |              |  |   | B. COUNTY<br>27-14  |   |  |  |
|   |              |  |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |   |  |  |
|   |              |  |   | Baltimore   |   |  |  |
|   |              |  |   | D. STREET ADDRESS (If rural, give location)   |   |  |  |
|   |              |  |   | 4 Upland Road   |   |  |  |
| 5. SEX<br>M   | 6. RACE<br>W | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>Married                      | 8. DATE OF BIRTH<br>7/20/1882             | 9. AGE (In years lost birthday)<br>82   | 10. If Under 1 Tr. Months Days Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |              |  | 11. BIRTHPLACE (State or foreign country) |   | 12. CITIZEN OF WHAT COUNTRY?              |  |  |
| Advertising-Retired Advertisement   |              |  | Canada                                    |   | U.S.A.                                    |  |  |
| 13. FATHER'S NAME   |              |  |   | 14. MOTHER'S MAIDEN NAME  |   |  |  |
| James Hardwell  |              |  |   | Florence Roddy  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |              |  | 16. SOCIAL SECURITY NO.                   |   | 17. INFORMANT ADDRESS                     |  |  |
| No  |              |  | 057-10-0587                               |   | Mrs. Marie L. Hardwell (Same)             |  |  |
| 18. 332X1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |              |  |   | CAUSE OF DEATH<br>(A) Cerebral thrombosis<br>DUE TO<br>(B)<br>DUE TO<br>(C)           |   | INTERVAL BETWEEN ONSET AND DEATH<br>3 mo.                            |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. arteriosclerotic heart disease   |              |  |   |   |   |  |  |
| 19A. DATE OF OPERATION  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 0   |              |  |   |   |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |   |  |  |
|   |              |  |   |   |   |  |  |
| 21D. TIME OF INJURY (APPROX.)   |              | 21E. INJURY OCCURRED   |   | 21F. HOW DID INJURY OCCUR?  |   |  |  |
|   |              | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |   |   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 7/28 1955 to 4/11 1965, that (I) (we) lost saw the deceased alive on 4/11/65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |              |  |   |   |   |  |  |
| 23A. SIGNATURE<br>William F. Renner   |              |  |   | 23B. DATE SIGNED  |   |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |              |  |   | 23D. ADDRESS  |   |  |  |
| William F. Renner   |              |  |   | 11 W. 29th St., Baltimore, Md.  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |              | 24B. DATE  |   | 24C. NAME of CEMETERY or CREMATORY  |   | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial  |              | 4/14/1965  |   | Greenmount  |   | Baltimore, Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |              | 25B. NAME OF REGISTRAR   |   | 25C. FUNERAL DIRECTOR ADDRESS   |   |  |  |
| APR 13 1965   |              | H.W. Jenkins & Sons Co.  |   | 4905 York Rd. Balto. 12, Md.  |   |  |  |





R-260

To be approved

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3928   |         |  |                  | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3928   |  |
|---|---------|--|------------------|---|--|--|--|
| M.E. CASE NO.   |         |  |                  | CERTIFICATE OF DEATH  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  |                  | 2. DATE AND HOUR OF DEATH   |  |  |  |
| Doris B. Rozier   |         |  |                  | April 12, 1965 4:55 A.M.  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |         |  |                  | A. STATE B. COUNTY  |  |  |  |
| Edgewood Nursing Home   |         |  |                  | Maryland 27-10  |  |  |  |
|   |         |  |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |  |  |
|   |         |  |                  | Baltimore   |  |  |  |
|   |         |  |                  | D. STREET ADDRESS (If rural, give location)   |  |  |  |
|   |         |  |                  | 706 McCabe Ave.   |  |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)                                     | 8. DATE OF BIRTH | 9. AGE (In years lost birthday)   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |  |
| F   | W       | Widowed  | 1/17/1890        | 75  |  |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Housewife   |         | Own Home   |                  | Baltimore, Maryland   |  | U.S.A.   |  |
| 13. FATHER'S NAME   |         |  |                  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| George Breitschweidt  |         |  |                  | Dorothy Nagel   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS   |  |  |  |
| No  |         | 218-18-1658  |                  | Charles Dishler, 7002 Kenleigh Rd. (12)   |  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  |         |  |                  | CAUSE OF DEATH  |  |  |  |
| 422.171 E 903.4   |         |  |                  | Arteriosclerotic Cordia 8 years   |  |  |  |
| ANTECEDENT CAUSES   |         |  |                  | Vascular Disease  |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  |                  |   |  |  |  |
| II  |         |  |                  |   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |                  | Fracture Inferior Ramus Left Ventr 3 mos.   |  |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 0   |         |  |                  | no  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)     |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |
|   |         | Home   |                  | 706 McCabe Ave. Balto 12/12   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| Jan. 11 1965 10 AM  |         | While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> |                  | Fell in bedroom of her apartment  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 1965 to April 1965, and that (I) (we) lost saw the deceased alive on 9 April 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death. |         |  |                  |   |  |  |  |
| 23A. SIGNATURE  |         |  |                  | 23B. DATE SIGNED  |  |  |  |
| Wm. H. Kammer Jr.   |         |  |                  | 12 April 1965   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |                  | 23D. ADDRESS  |  |  |  |
| William H. Kammer, Jr. M.D.   |         |  |                  | 6011 York Road, Baltimore, Md.  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                  | 24C. NAME of CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| Burial  |         | 4/14/1965  |                  | Moreland Memorial Park  |  | Parkville, Balto. Co., Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS   |  |  |  |
| APR 13 1965   |         | Robert E. Jenkins  |                  | H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.                                  |  |  |  |

THE  
OF

OF

OF

1861

1861

1861

BIRTH NO. 65 3929 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3929

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

LARRY HARRY E HAWKINS

2. DATE AND HOUR PRONOUNCED DEAD

4/9/65 5:05 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

St. Joseph Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1401 N. Caroline St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

9-22-1945

9. AGE (In years  
last birthday)

19

11 Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

FOOD HANDLER

10B. KIND OF BUSINESS OR INDUSTRY

JOHN HOPKIN HOSP.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

NORMAN HAWKINS

14. MOTHER'S MAIDEN NAME

HELEN GILLIAM

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

212-42-8865

17. INFORMANT

ADDRESS

NORMAN HAWKINS 144 S. HILTON

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, ashenia, etc. It means the disease,  
injury or complication which caused death.)(A) Gunshot wound of chest  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

bar

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Dellis Bar 1901 E. Oliver St.

21D. TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 9 65 4:30p

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

shot during altercation

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4/10/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4-15-65

23C. NAME of CEMETERY or CREMATORY

MT. CALVARY

23D. LOCATION

(City, town, or county)

(State)

A.A. COUNTY

24A. DATE REC'D BY HEALTH DEPT.

APR 18 1965

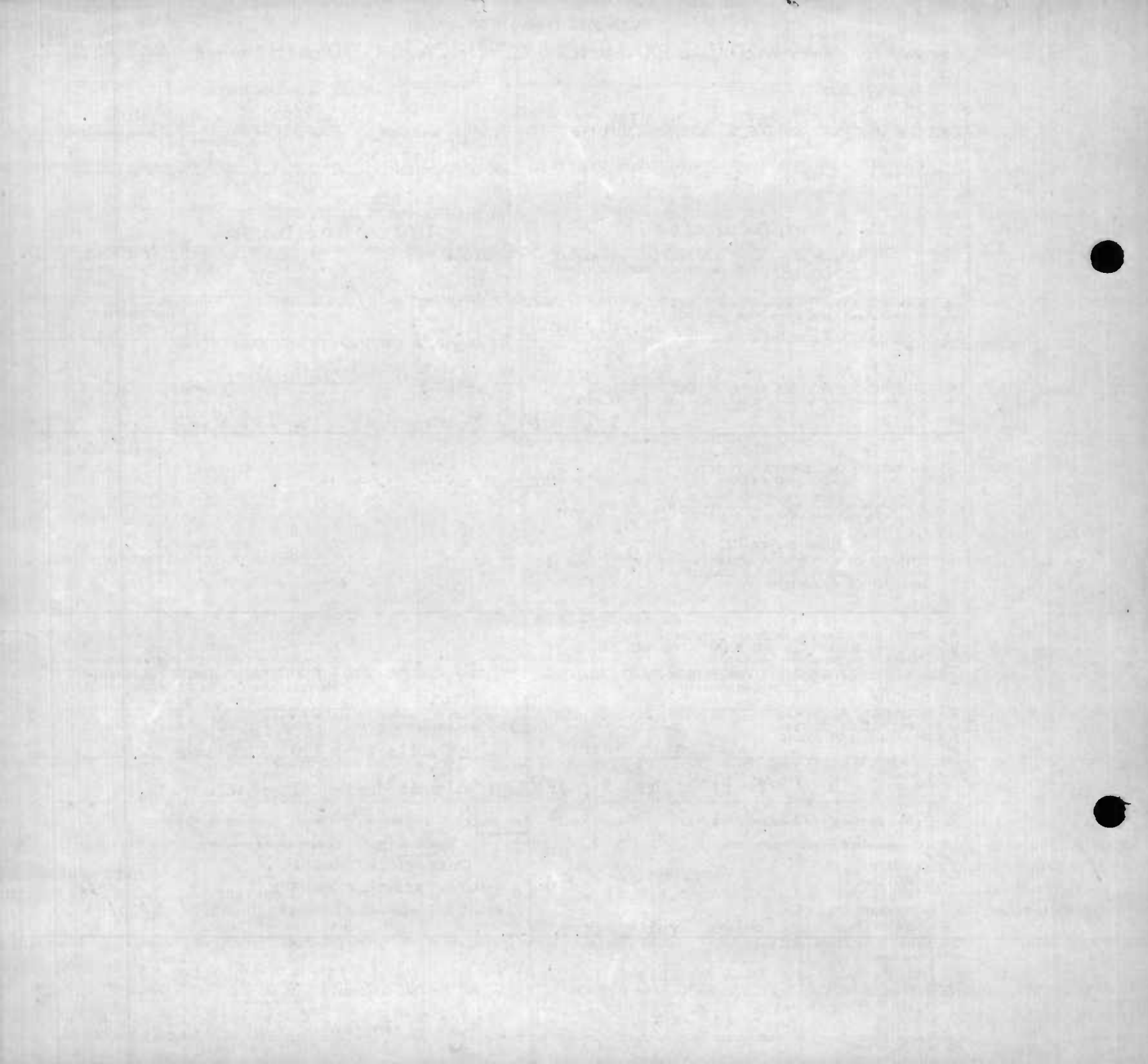
24B. NAME OF REGISTRAR

Rudiger E. Breiteneker, M.D.

24C. FUNERAL DIRECTOR

ADDRESS

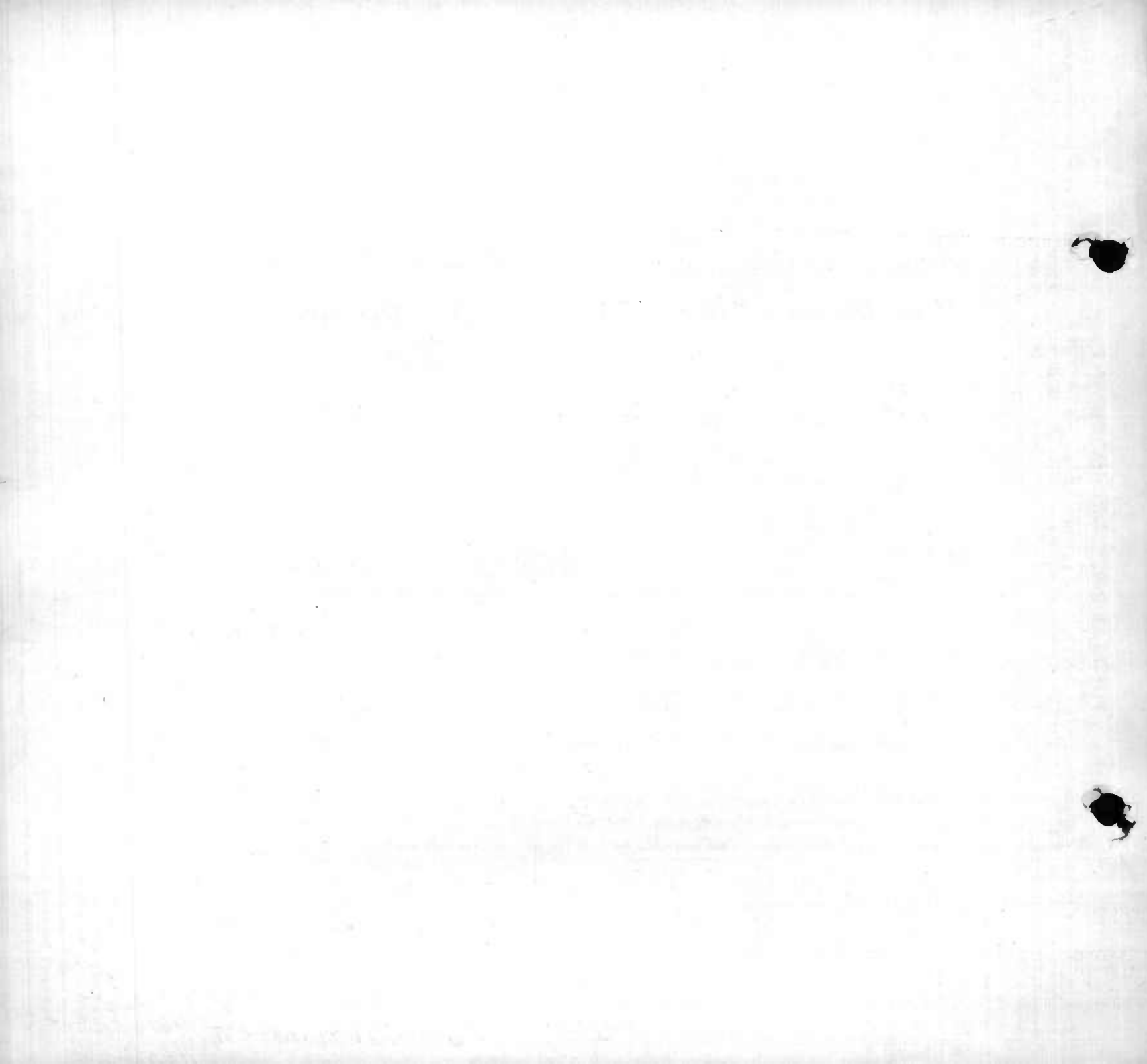
JOSEPH KNIGHT 1639 N. BROADWAY



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |                                  |  |   |
|---|------------------|---|----------------------------------|--|---|
| BIRTH NO. 65 3930   |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                                  | Registered No. 65 3930   |   |
| M.E. CASE NO.   |                  | 1. NAME OF DECEASED<br>(Type or Print) George Hepp Hepp   |                                  | 2. DATE AND HOUR OF DEATH<br>4-10-65   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)   |                                  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br>824 STANford Rd   |                  | A. STATE Maryland<br>B. COUNTY 28-04<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>824 STANford Rd<br>D. STREET ADDRESS (If rural, give location) |                                  |  |   |
| 5. SEX<br>Male  | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (Specify)<br>Widowed   | 8. DATE OF BIRTH<br>JUNE 6, 1889 | 9. AGE (In years last birthday)<br>76 yrs  | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Oil Business & meat Cutter   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                                  | 11. BIRTHPLACE (State or foreign country)<br>Philadelphia  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                    |
| 13. FATHER'S NAME<br>George Hepp  |                  | 14. MOTHER'S MAIDEN NAME<br>Unknown   |                                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No |   |
| 16. SOCIAL SECURITY NO.<br>215-23-9798  |                  | 17. INFORMANT<br>James Lindsay  |                                  | ADDRESS<br>116 N Paca St   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>CORONARY OCCLUSION  |                  | CAUSE OF DEATH<br>(A) DUE TO<br>CORONARY INSUFFICIENCY<br>(B) DUE TO<br>ARTERIO-SCLEROTIC CVD<br>(C) EMPHYSEMA  |                                  | INTERVAL BETWEEN ONSET AND DEATH<br>1 hr<br>5 yrs<br>5 yrs   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Malnutrition - The spleen (Rt)  |                  |   |                                  |  |   |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |                                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                       |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from June 1957 to 4-10-1965, that (I) (we) last saw the deceased alive on 4-9-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 8:20 AM |                  |   |                                  |  |   |
| 23A. SIGNATURE<br>Thomas R. Abbott  |                  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |                                  | 23B. DATE SIGNED<br>4-10-65  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>Thomas R. Abbott  |                  | 23D. ADDRESS<br>4509 Liberty Bell Ave   |                                  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4-14-65  |                                  | 24C. NAME OF CEMETERY OR CREMATORY<br>Forest Hills Cemetery - Philadelphia, Pa                                 |   |
| 24D. LOCATION<br>(City, town, or county) (State)  |                  |   |                                  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 13 1965  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                                  | 25C. FUNERAL DIRECTOR<br>E. S. Smith   |   |
|   |                  |   |                                  | ADDRESS<br>4600 Liberty Hgts Ave   |   |

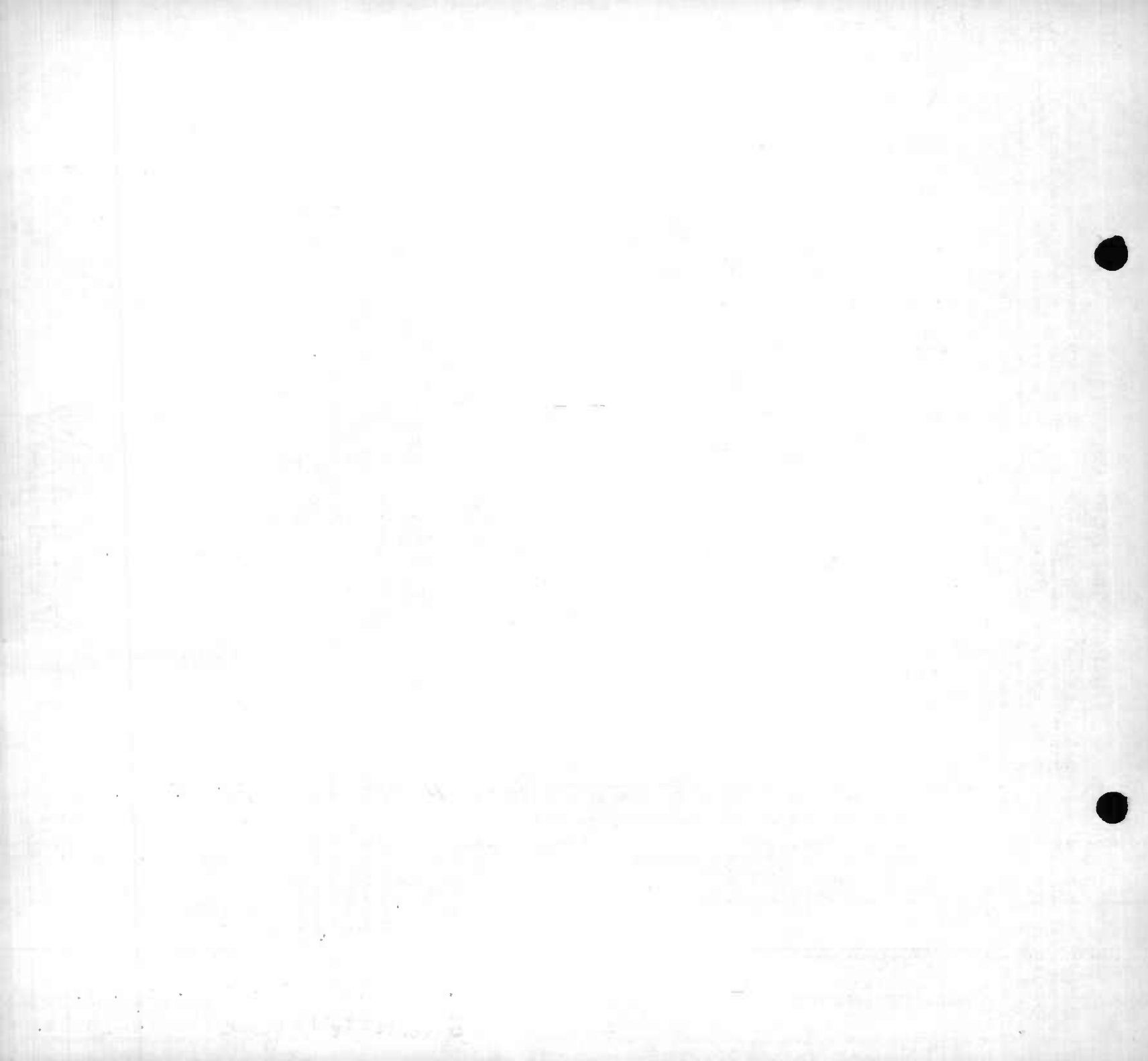




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | Certificate of Death  |  | Registered No. 65 3931  |  |
|---|--|--|--|---|--|---|--|
| BIRTH NO. 65 3931   |  | M.E. CASE NO.  |  | 1. NAME OF DECEASED (Type or Print) Mr. ALFRED DETOTA   |  | 2. DATE AND HOUR OF DEATH 4/10/65 6:00 P.M.   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |  | CHURCH HOME AND HOSPITAL   |  | A. STATE B. COUNTY 402 S. EXETER ST BALTIMORE 02 MARYLAND   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTIMORE MARYLAND 3-02             |  |
| D. STREET ADDRESS (If rural, give location) 402 S. EXETER STREET  |  | 5. SEX Male  |  | 6. RACE W   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) SINGLE   |  |
| 8. DATE OF BIRTH 7-3-13   |  | 9. AGE (In years last birthday) 51   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <del>house</del> <del>as</del> <del>Richard</del> <del>Paul</del> <del>Co.</del> <del>Cath</del> |  | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland   |  |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 13. FATHER'S NAME John Detota  |  | 14. MOTHER'S MAIDEN NAME Albina Guasimo   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no |  |
| 16. SOCIAL SECURITY NO. 213-09-5726   |  | 17. INFORMANT Dr. Tan  |  | ADDRESS Church Home & Hospital  |  | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |  | ANTECEDENT CAUSES  |  | DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | CAUSE OF DEATH  |  |
| (A) DUE TO Adverse carcinoma of stomach   |  | 10 days  |  | (B) DUE TO Acute cardiac failure  |  | 2 days  |  |
| (C) DUE TO Myocardial infarction  |  | 2 days   |  | (D) DUE TO Respiratory failure  |  | 2 days  |  |
| due to Metastasis of carcinoma  |  |  |  |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION 1 April 1, 1965  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) No  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 11 1965 to April 10 1965, that (I) (we) last saw the deceased alive on 4/10/65 April 10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  | 23A. SIGNATURE Manuel J. Tan   |  | 23B. DATE SIGNED April 10, 1965   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)  |  | 23D. ADDRESS Church Home & Hospital  |  | 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |  | 24B. DATE 4/14-65   |  |
| 24C. NAME of CEMETERY or CREMATORY Holy Redeemer Cem.   |  | 24D. LOCATION 4430 Belair Rd. Balt. Md.  |  | 25A. DATE REC'D BY HEALTH DEPT. APR 13 1965   |  | 25B. NAME OF REGISTRAR  |  |
| 25C. FUNERAL DIRECTOR   |  | 25D. ADDRESS 322 S. High St.   |  |   |  |   |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |                                |  |   |  |   |  |  |   |  |  |
|---|--|--------------------------------|--|---|--|---|--|--|---|--|--|
| BIRTH NO. 65 3932   |  |                                |  |   |  | CERTIFICATE OF DEATH  |  |  | Registered No. 65 3932                      |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>CATHERMAN, CHARLES LUTHER</b>   |  |                                |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>4-10-65 9:40 P.M.</b>   |  |  |   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>ST. AGNES HOSPITAL</b>  |  |                                |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>Balt</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b><br>D. STREET ADDRESS (If rural, give location)<br><b>53 RD 717 KAHN DRIVE</b> |  |  |   |  |  |
| 5. SEX<br><b>MALE</b>   |  | 6. RACE<br><b>WHITE</b>        |  | 7. MARRIED, NEVER MARRIED<br><b>WIDOWED</b> <b>MARRIED</b> <b>DIVORCED</b> (specify)                      |  | 8. DATE OF BIRTH<br><b>3-15-18</b>  |  | 9. AGE (In years last birthday)<br><b>47</b>                               |   | 10. Under 1 Yr. Months: Days: Hours: Min.                            |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CUSTODIAN</b>   |  |                                |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>BD. OF EDUCATION</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b> |  |  |
| 13. FATHER'S NAME<br><b>CHARLES L CATHERMAN, SR. (DEC'D)</b>  |  |                                |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>ALICE CATHERMAN</b>  |  |  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES</b>  |  |                                |  | 16. SOCIAL SECURITY NO.<br><b>214268619</b>   |  | 17. INFORMANT ADDRESS<br><b>ST. AGNES HOSPITAL RECORDS BALTO. 29, MD</b>  |  |  |   |  |  |
| 18. <b>420.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |  |                                |  |   |  | CAUSE OF DEATH<br>(A) <b>Acute Anterior Septal Myocardial Infarct</b><br>DUE TO<br>(B) <b>Arteriosclerotic Cardiovascular Disease</b><br>DUE TO<br>(C)  |  |  | INTERVAL BETWEEN ONSET AND DEATH            |  |  |
|   |  |                                |  |   |  |   |  |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>4-10-65</b>  |  |                                |  |   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) <b>X</b>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>  |  |                                |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |   |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |  |                                |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-5-65</b> to <b>4-10-65</b> , that (I) (we) last saw the deceased alive on <b>4-10-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <b>XXXXX</b> view the body after death.   |  |                                |  |   |  |   |  |  |   |  |  |
| 23A. SIGNATURE<br><b>Raphael C. Meyers Jr.</b>  |  |                                |  |   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  |  | 23B. DATE SIGNED<br><b>4/10/65</b>          |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>RAPHAEL C. MEYERS JR.</b>  |  |                                |  |   |  | 23D. ADDRESS<br><b>ST. AGNES HOSPITAL</b>   |  |  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>Apr. 14-65</b> |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Baltimore National Cem.</b>                                      |  |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>5501 Frederick Ave</b> |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |  |                                |  | 25B. NAME OF REGISTRAR<br><b>John Della Noce</b>  |  |   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>322 S. High St.</b>                    |   |  |  |

THE UNITED STATES OF AMERICA

DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT  
WASHINGTON, D. C. 20250

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

Antelope Valley  
California

Antelope Valley

11/10/72

43-21-74 AM

65 3933

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

65 3933

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)Joseph  
Anthony Popoli

2. DATE AND HOUR OF DEATH

4-11-65

12:50 A.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland #212244. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

529 South Decker Avenue #21224

5. SEX

Male

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

7-7-90

9. AGE (In years  
last birthday)

74

If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Operator

10B. KIND OF BUSINESS OR INDUSTRY

Balto. Transit.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Lawrence Popoli

14. MOTHER'S MAIDEN NAME

Amelia Guarino

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

213-10-0945

17. INFORMANT ADDRESS

Anthony M. Popoli 1513 D llsway Rd. #4

RECORDS: B.C.H. 4940 Eastern Avenue #21224

18.

491X I  
DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, oshtenio, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

CAUSE OF DEATH

(A) Staphylococcal Pneumonia  
DUE TO(B)  
DUE TO

(C)

INTERVAL BETWEEN  
ONSET AND DEATH

2 Weeks

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)21E. INJURY OCCURRED  
While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 3-30-19 65 to 4-11-19 65,  
that (I) (we) last saw the deceased alive on 4-11-19 65 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Dr. Philip Zieve

M.D.

Attending  
Phys.Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

4-11-65

23C. PHYSICIAN'S  
NAME (Type)

Dr. Philip Zieve

M.D.

23D. ADDRESS

4940 Eastern Avenue #21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/14/65

24C. NAME of CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

25B. NAME OF REGISTRAR

APR 13 1965

25C. FUNERAL DIRECTOR

Schimmunek Funeral Home, Inc.

ADDRESS

3331 Brehms Lane #13

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3934  |                         |   |                                   | BALTIMORE CITY HEALTH DEPARTMENT   |   | Registered No. 65 3934   |  |
|--|-------------------------|---|-----------------------------------|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>ETHEL Frances E. Schuch</b>  |                         |   |                                   | 2. DATE AND HOUR OF DEATH<br><b>12:00 A.M. April 12, 1965</b>  |   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Maryland General Hospital</b>  |                         |   |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>26-02</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>5629 Frankford Ave. #21206</b> |   |  |  |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>                                | 8. DATE OF BIRTH<br><b>6-4-09</b> | 9. AGE (In years lost birthday)<br><b>55</b>   | 10. Under 1 Yr.<br>Months Days Hours Min. | 11. Under 24 Hrs.<br>Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Sales Woman</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Loft Candy</b>  |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |  |
| 13. FATHER'S NAME<br><b>Henry Ritz - Dec.</b>  |                         |   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Emma Jones - Dec.</b>   |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                         | 16. SOCIAL SECURITY NO.<br><b>218-12-2330</b>   |                                   | 17. INFORMANT<br><b>Gerard W. Schuch above - husband</b>   |   |  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>420.1 I Atelectatic Pneumonia</b><br>DUE TO<br><b>Myocardial Infarction</b><br>DUE TO<br><b>20 days.</b>        |                         |   |                                   | INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| 19. MEDICAL CERTIFICATION<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |                                   |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                   | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Apr 4 1965</b> to <b>Apr 12 1965</b> , that (I) (we) last saw the deceased alive on <b>12 AM Apr 12 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |                                   |  |   |  |  |
| 23A. SIGNATURE<br><b>Kyoungho M. Cynn</b>  |                         |   |                                   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |   | 23B. DATE SIGNED<br><b>Apr 12 65</b>                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>KYOUNGHO M. CYNN</b>  |                         |   |                                   | 23D. ADDRESS<br>M.D. <b>Md. General Hospital</b>   |   |  |  |
| 24A. BURIAL REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4/14/65</b>   |                                   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Parkwood Cemetery</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>P. E. E. Felt</b>  |                                   | 25C. FUNERAL HOME<br><b>Schimmek Funeral Home, Inc.</b>  |   | ADDRESS<br><b>3331 Prehms Lane #13</b>                                 |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                      |  |  | Registered No. <u>65 3935</u>  |   |
|---|----------------------|--|--|--|---|
| BIRTH NO. <u>65 3935</u>  |                      | <b>CERTIFICATE OF DEATH</b>  |  |  |   |
| M.E. CASE NO. <u>J</u>  |                      |  | 2. DATE AND HOUR OF DEATH <u>4-11-65</u> <u>5:50 A.M.</u>  |  |   |
| 1. NAME OF DECEASED (Type or Print) <u>Louis Schisler</u>   |                      |  | 4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>26-36</u> |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Maryland #21224</u>   |                      |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>Baltimore</u>  |  |   |
|   |                      |  | D. STREET ADDRESS (If rural, give location)<br><u>6123 Shipview Way #21224</u>   |  |   |
| 5. SEX <u>Male</u>  | 6. RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <u>Widowed</u>                                  | B. DATE OF BIRTH <u>3-8-87</u>   | 9. AGE (In years last birthday) <u>78</u>  | If Under 1 Yr. Months Days Hours Min. If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>   |  | 11. BIRTHPLACE (State or foreign country) <u>Maryland-Baltimore</u>                          |   |
| 13. FATHER'S NAME <u>Charles Schisler</u>   |                      |  | 14. MOTHER'S MAIDEN NAME <u>Chrescentia Brauch</u>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                      | 16. SOCIAL SECURITY NO. <u>none</u>  |  | 17. INFORMANT <u>May Lesser</u> ADDRESS <u>6123 Shipview Way #24 -dght.</u>                  |   |
|   |                      |  |  | RECORDS: B.C.H. 4940 Eastern Avenue #21224   |   |
| 18. <u>154X I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                      |  | (A) <u>Pneumonia</u><br>DUE TO   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>1 Week</u>                 |
|   |                      |  | (B) <u>Carcinoma of Rectum</u><br>DUE TO   |  |   |
|   |                      |  | (C) _____  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                      |  |  |  |   |
| 19A. DATE OF OPERATION <u>0 Feb. 65</u>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of Rectum</u>                            |  | 20A. AUTOPSY? (Yes or No) <u>No</u>  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>4-9-</u> <u>19 65</u> to <u>4-11</u> <u>19 65</u> , that (I) (we) last saw the deceased alive on <u>4-11</u> <u>19 65</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |  |  |  |   |
| 23A. SIGNATURE <u>Philip Zieve</u>  |                      |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>     |  | 23B. DATE SIGNED <u>4-11-65</u>                                   |
| 23C. PHYSICIAN'S NAME (Type) <u>Dr. Philip Zieve</u>  |                      |  | 23D. ADDRESS <u>4940 Eastern Avenue #21224</u>   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>  |                      | 24B. DATE <u>4/14/65</u>   |  | 24C. NAME of CEMETERY or CREMATORY <u>Moreland Memorial Cemetery</u>                         |   |
|   |                      |  |  | 24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>                          |   |
| 25A. DATE REC'D BY HEALTH DEPT. <u>APR 13 1965</u>  |                      | 25B. NAME OF REGISTRAR <u>Robert C. Schisler</u>   |  | 25C. FUNERAL DIRECTOR <u>Schisler Funeral Home, Inc.</u> ADDRESS <u>3331 Brenns Lane #13</u> |   |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3936  |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3936   |   |
|--|-------------------------|---|--|---|--|--|---|
| M.E. CASE NO.  |                         |   |  | CERTIFICATE OF DEATH  |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SIGNE WAGLIE</b>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>APRIL 10, 1965</b>  |  | <b>7 am</b> M.   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Johns Hopkins Hospital</b>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>6-01</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>227 North Kenwood Avenue #24</b> |  |  |   |
| 5. SEX<br><b>female</b>  | 6. RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>widowed</b>                                | 8. DATE OF BIRTH<br><b>Oct. 10, 1884</b> | 9. AGE (In years last birthday)<br><b>80</b>  | If Under 1 Yr. Months: Days:   | If Under 24 Hrs. Hours: Min.   |   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Practical Nurse</b>  |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY        |   | 11. BIRTHPLACE (State or foreign country)<br><b>Norway</b>                 |  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                         |   |  |   |  |  |   |
| 13. FATHER'S NAME<br><b>Unknown Nilsen</b>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>  |  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                         |   | 16. SOCIAL SECURITY NO.                  |   | 17. INFORMANT ADDRESS<br><b>Nelson Waglie 7938 Eastdale Road #24 - son</b> |  |   |
| 18. <b>420.11</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                         |   |  | CAUSE OF DEATH<br><b>Ischemic Heart Disease</b><br><b>Coronary Thrombosis</b><br><b>3 months</b>  |  | INTERVAL BETWEEN ONSET AND DEATH                                       |   |
|  |                         |   |  |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 4</b> 19 <b>65</b> to <b>April 10</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>April 4</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |  |   |  |  |   |
| 23A. SIGNATURE<br><b>Albert J. Sikorsky</b> M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                         |   |  | 23B. DATE SIGNED<br><b>April 19, 1965</b>   |  |  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Albert Sikorsky</b> M.D.  |                         |   |  | 23D. ADDRESS<br><b>2939 McElderry Street 21205</b>  |  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4/13/65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Albert J. Sikorsky</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Schimunek Funeral Home, Inc.</b>  |  |  | 25D. ADDRESS<br><b>2601-03-05 E. Madison Street</b> |

4

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

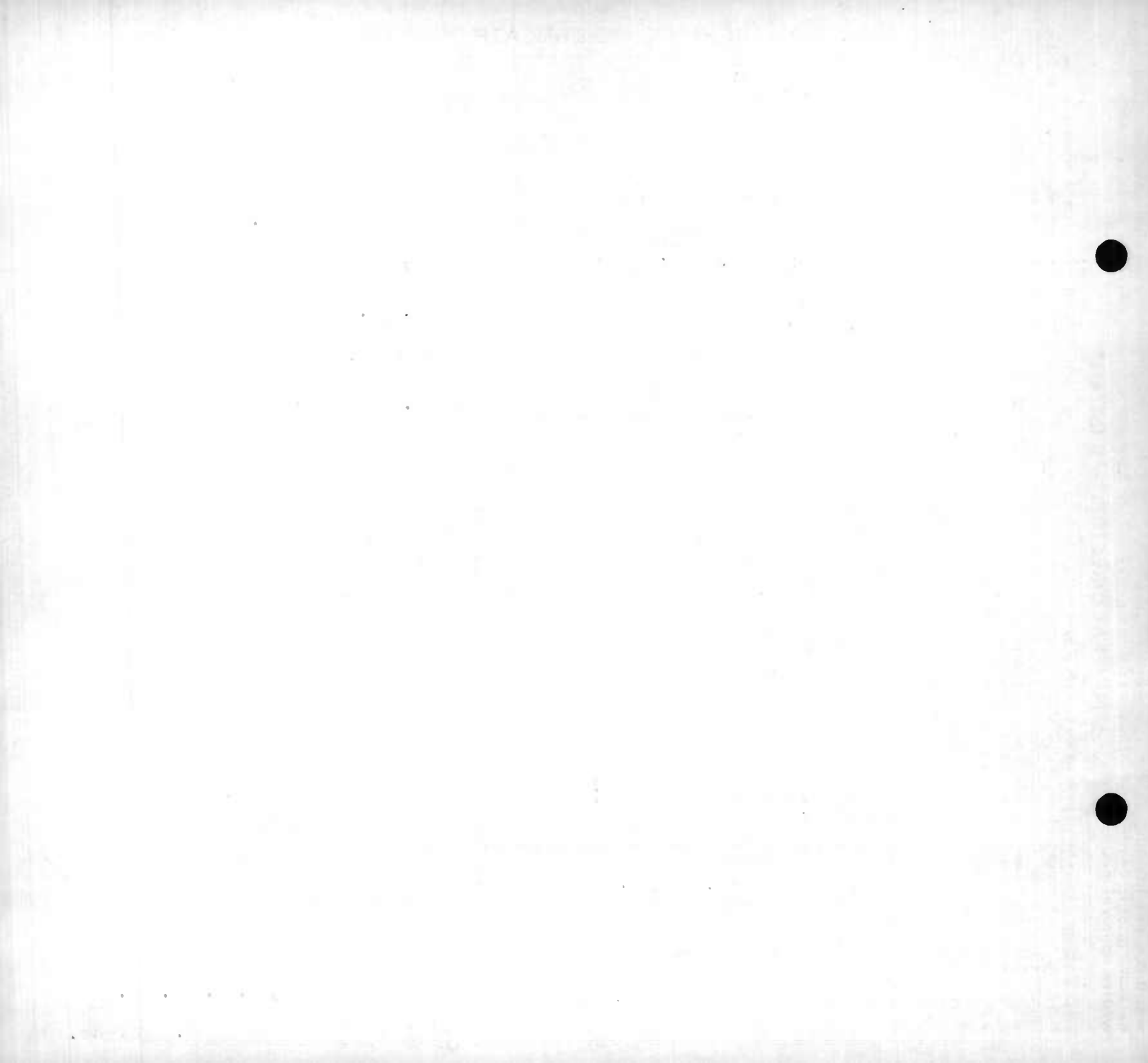
| BIRTH NO. 65 3937  |                         |   |  | BALTIMORE CITY HEALTH DEPARTMENT   |                            | Registered No. 65 3937   |                             |
|--|-------------------------|---|--|--|----------------------------|--|-----------------------------|
| M.E. CASE NO.  |                         |   |  | CERTIFICATE OF DEATH   |                            |  |                             |
| 1. NAME OF DECEASED<br>(Type or Print) <b>IRVIN Woodland Jones</b>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>APRIL 11, 1965</b>   |                            |  |                             |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>SINAI Hospital</b>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>15-12</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b><br>D. STREET ADDRESS (If rural, give location)<br><b>3729 PARK Heights AVE</b> |                            |  |                             |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>                                | 8. DATE OF BIRTH<br><b>JULY 18, 1893</b> | 9. AGE (In years last birthday)<br><b>71</b>   | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>BILL COLLECTOR</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>UTILITIES</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                          |                             |
| 13. FATHER'S NAME<br><b>FRANK JONES</b>  |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><b>EMMA. ?</b>   |                            |  |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>WORLD WAR I 212-05-5527</b>   |  | 17. INFORMANT<br><b>ANNA JONES</b>   |                            | ADDRESS<br><b>3729 PARK Heights AVE</b>                                |                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>422.21 x 260 X</b>  |                         |   |  | CAUSE OF DEATH<br>(A) DUE TO <b>Myocardial infarction 3 years.</b><br>(B) DUE TO <b>Heart failure 1 year.</b><br>(C) <b>Heart failure, acute 1 week.</b>   |                            | INTERVAL BETWEEN ONSET AND DEATH                                       |                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>  |                         |   |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>Diabetes Mellitus</b>   |                            |  |                             |
| 19A. DATE OF OPERATION<br><b>D</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |  |                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |                            |  |                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Feb 16</b> 19 <b>65</b> to <b>April 10</b> 19 <b>65</b> .<br>that (I) (we) last saw the deceased alive on <b>April 10</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) <del>did</del> <b>did not</b> view the body after death. |                         |   |  |  |                            |  |                             |
| 23A. SIGNATURE<br><b>Joseph R. Myerowitz</b>   |                         |   |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                            | 23B. DATE SIGNED<br><b>4-12-65</b>                                     |                             |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Joseph R. MYEROWITZ</b>   |                         |   |  | 23D. ADDRESS<br><b>5145 PARK HEIGHTS AVE BALTIMORE, Md.</b>  |                            |  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>4-14-65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>LONDON PARK</b>   |                            | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, Md.</b> |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Geo. L. Schwab FUNERAL HOME</b><br><b>Charles E. Miller 2101 Indivick</b>  |                            |  |                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

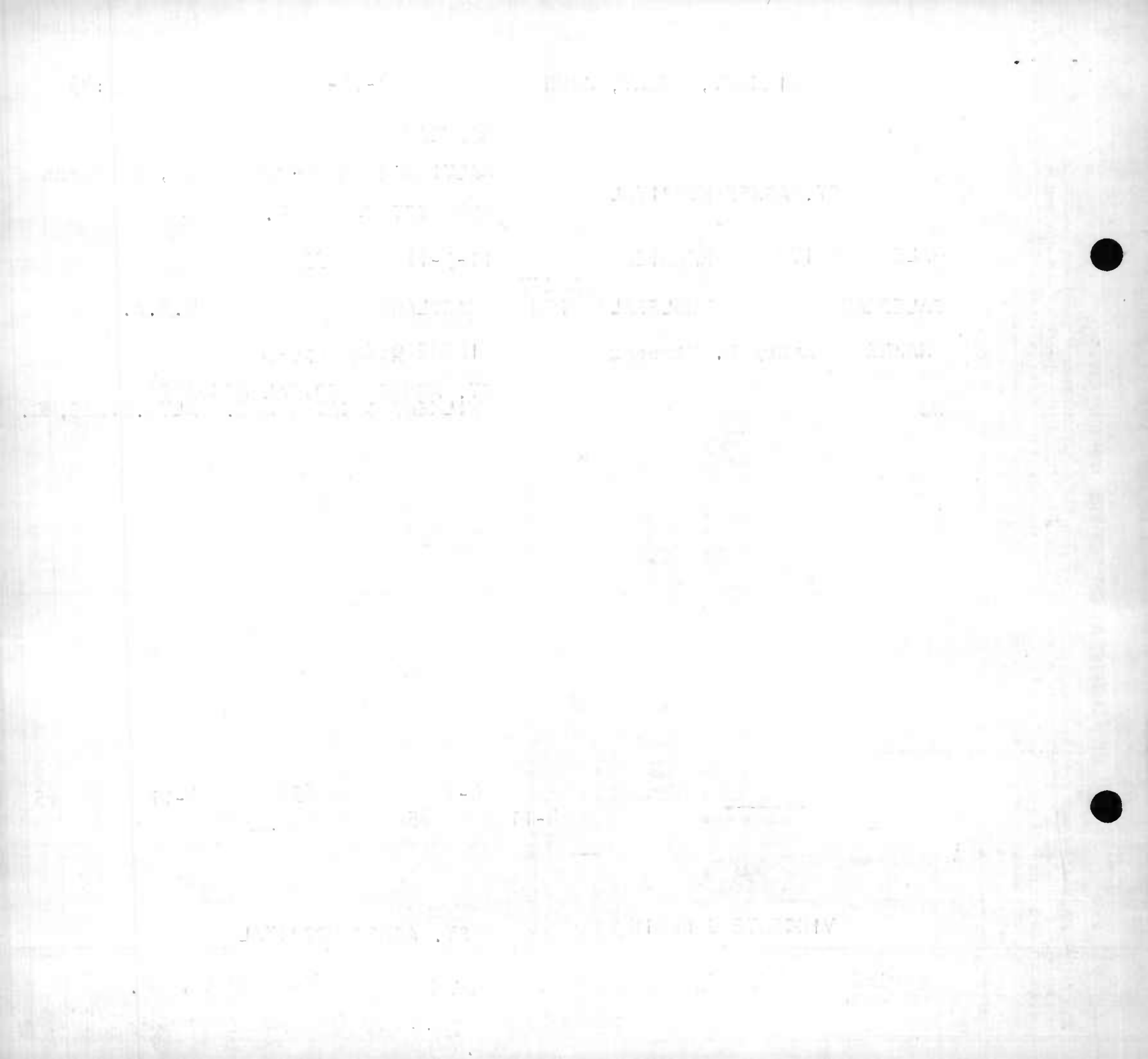
| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   | 65 3938   |                            | Registered No. 65 3938  |                             |
|---|-------------------------|---|---|---|----------------------------|---|-----------------------------|
| BIRTH NO. 65 3938   |                         | <b>CERTIFICATE OF DEATH</b>   |   |   |                            |   |                             |
| M.E. CASE NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Harvey S. Forrester</b>   |   | 2. DATE AND HOUR OF DEATH<br><b>4-11-65 10:25 A.M.</b>                                      |                            |   |                             |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND   |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>24-03</b> |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b> |                            |   |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><b>G. Balto. Gen. Hosp.</b>   |                         | D. STREET ADDRESS (If rural, give location)<br><b>1200 Riverside Ave.</b>   |   |   |                            |   |                             |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Married</b>  | 8. DATE OF BIRTH<br><b>March 15, 1912</b> | 9. AGE (In years last birthday)<br><b>53</b>  | If Under 1 Yr. Months Days |   | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Iron Worker</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Construction</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b>                              |                            | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>                                    |                             |
| 13. FATHER'S NAME<br><b>Sellman Forrester</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Theresa Coast</b>  |   |   |                            |   |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Doris N. Forrester</b>  |                            | ADDRESS<br><b>1200 Riverside Ave</b>  |                             |
| 18. <b>430.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocardial Infarction</b>  |                         | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b>  |                            |   |                             |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  |                         |   |   |   |                            |   |                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   |   |   |                            |   |                             |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?            |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                    |                            |   |                             |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                   |   | 21F. HOW DID INJURY OCCUR?  |                            |   |                             |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-11-65</b> to <b>4-11-65</b> , that (I) (we) last saw the deceased alive on <b>4-11-65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |   |   |                            |   |                             |
| 23A. SIGNATURE<br><b>John Weagly</b>  |                         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>        |   | 23B. DATE SIGNED<br><b>4-11-65</b>  |                            |   |                             |
| 23C. PHYSICIAN'S NAME (Type)  |                         | M.D.  |   | 23D. ADDRESS  |                            |   |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4 14 1965</b>   |   | 24C. NAME of CEMETERY or CREMATORY<br><b>Cedar Hill</b>                                     |                            | 24D. LOCATION (City, town, or county) (State)<br><b>Brooklyn, A. A. Co. Md.</b> |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Stapher</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Mc Gally</b>  |                            | ADDRESS<br><b>130 E. Fort Ave.</b>  |                             |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | Registered No. 65 3939   |  |
|--|--|---|--|--|--|
| BIRTH NO. 65 3939  |  | CERTIFICATE OF DEATH  |  |  |  |
| M.E. CASE NO.  |  | 1. NAME OF DECEASED<br>(Type or Print) VINCENT, HENRY, JOHN   |  | 2. DATE AND HOUR OF DEATH<br>4-11-65 5:45 A.M.   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                                   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>ST. AGNES HOSPITAL   |  | A. STATE MARYLAND<br>B. COUNTY GREEN HAVEN, PASADENA  |  |  |  |
| 5. SEX MALE  |  | 6. RACE WHITE   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN   |  | 10B. KIND OF BUSINESS OR INDUSTRY MARKET WHOLESALE FISH   |  | 11. BIRTHPLACE (State or foreign country) MARYLAND                                     |  |
| 13. FATHER'S NAME MARKX Henry W. Vincent   |  | 14. MOTHER'S MAIDEN NAME IRENE OLVER  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS WILKENS & CATON AVE. BALTO. 21229 MD. |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) DUE TO Carcinoma Esophagus<br>(B) DUE TO generalized abdominal viscera metastasis & lungs.<br>(C) |  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| MEDICAL CERTIFICATION  |  |   |  |  |  |
| 19A. DATE OF OPERATION 2   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) YES  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)               |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>               |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4-9-19-65 to 4-11-19-65, that (I) (we) last saw the deceased alive on 4-11-19-65 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                             |  |   |  |  |  |
| 23A. SIGNATURE Vincent G. Rubin M.D.   |  |   |  | 23B. DATE SIGNED 4/11/65   |  |
| 23C. PHYSICIAN'S NAME (Type) VINCENTE G RUBIN  |  |   |  | 23D. ADDRESS ST. AGNES HOSPITAL  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE 4/14/65   |  | 24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial                                 |  |
| 24D. LOCATION (City, town, or county) Glen Burnie, Md.   |  | 24E. DATE REC'D BY HEALTH DEPT. APR 13 1965   |  |  |  |
| 25A. NAME OF REGISTRAR E. J. Rubin   |  | 25B. NAME OF REGISTRAR E. J. Rubin  |  | 25C. FUNERAL DIRECTOR G. A. L. FUNERAL HOME, BALTIMORE, Md.                            |  |

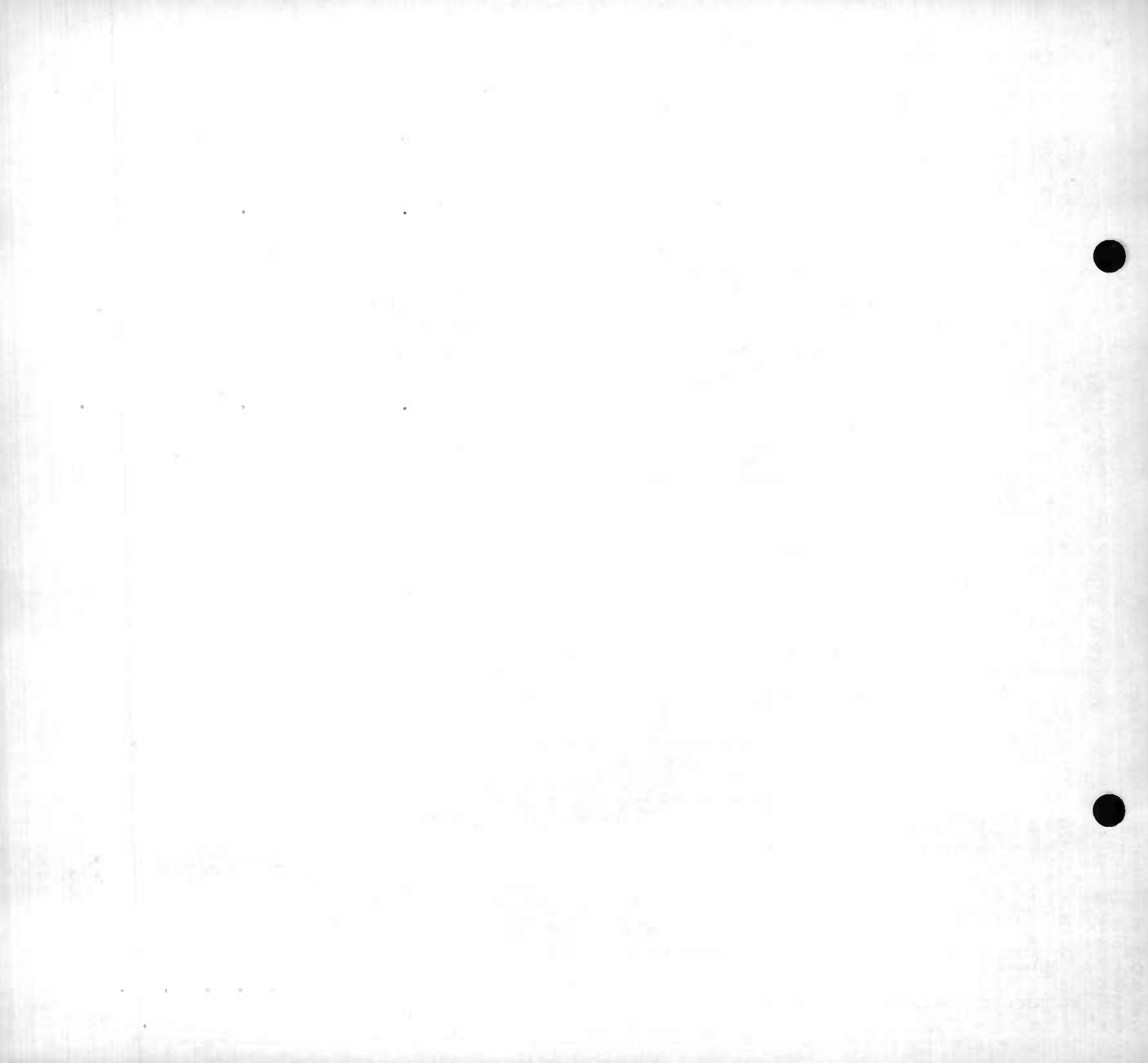




FUNERAL DIRECTOR: IMPORTANT

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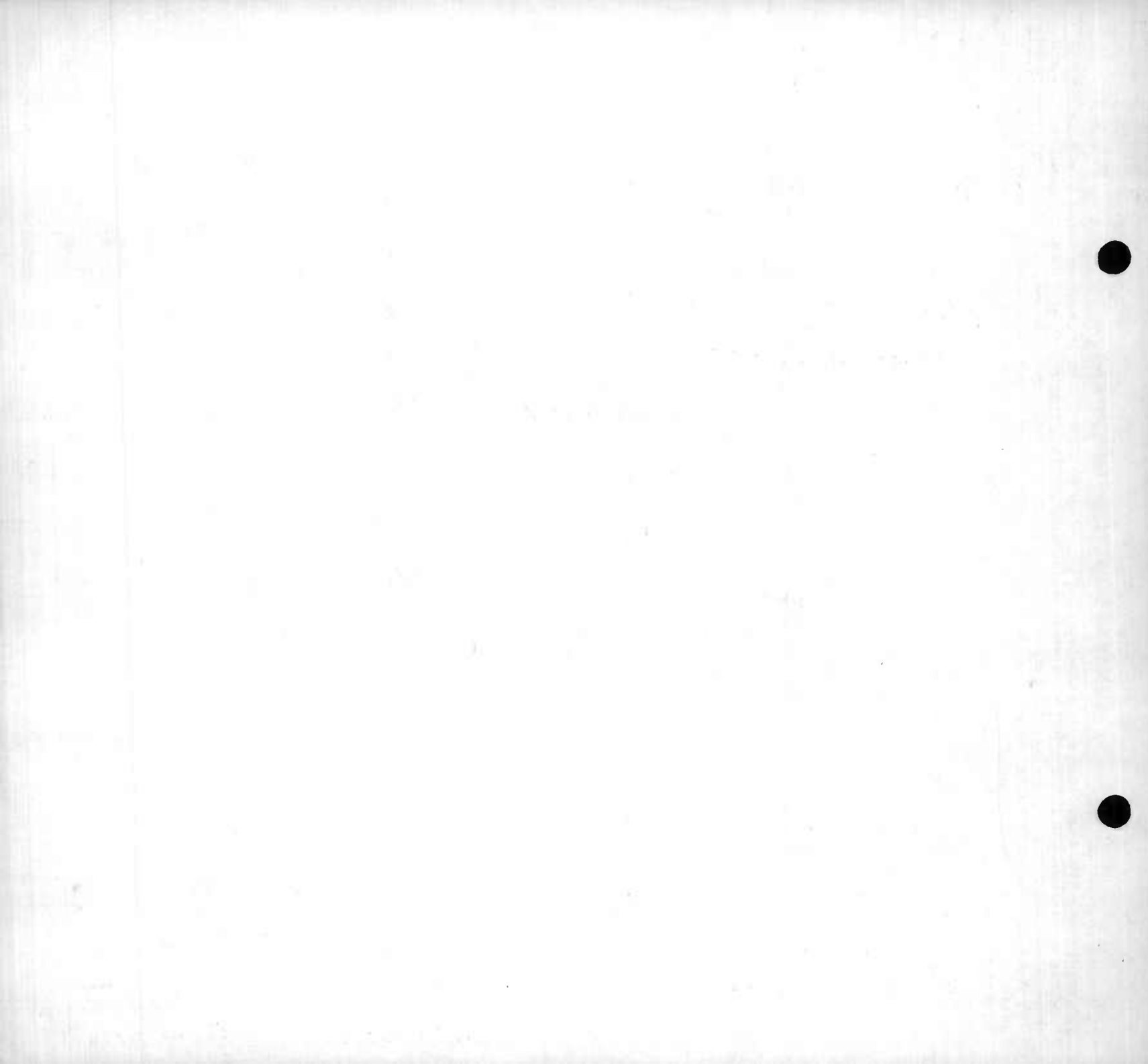
| BALTIMORE CITY HEALTH DEPARTMENT  |                     |  |                                    | Registered No. <span style="font-size: 1.2em;">65 3940</span>   |   |
|---|---------------------|--|------------------------------------|---|---|
| BIRTH NO. <span style="font-size: 1.2em;">65 3940</span>  |                     | <b>CERTIFICATE OF DEATH</b>  |                                    |   |   |
| M.E. CASE NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <i>Brown, Harold D.</i>   |                                    | 2. DATE AND HOUR OF DEATH<br><i>4-11-65 1 57 P.M.</i>   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>227 E. Montgomery St.</i><br>B. COUNTY <i>22-01</i>                                     |                                    | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore, Maryland</i> |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>South Baltimore General Hospital</i>   |                     | D. STREET ADDRESS (If rural, give location)<br><i>227 E. Montgomery St.</i>  |                                    |   |   |
| 5. SEX<br><i>M</i>  | 6. RACE<br><i>W</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>MARRIED</i>   | 8. DATE OF BIRTH<br><i>2-12-22</i> | 9. AGE (In years last birthday)<br><i>43</i>  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Oiler</i>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY  |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>West Virginia</i>                                     |   |
| 13. FATHER'S NAME<br><i>Unknown Brown</i>   |                     | 14. MOTHER'S MAIDEN NAME<br><i>Alma Rodenck</i>  |                                    | 12. CITIZEN OF WHAT COUNTRY?<br><i>U S A</i>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |                     | 16. SOCIAL SECURITY NO.  |                                    | 17. INFORMANT<br><i>Rose C. Brown</i> <i>227 E. Montgomery St.</i>                                    |   |
| 18. <i>163X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     | CAUSE OF DEATH<br><i>Mucoid adenocarcinoma of the lung with metastasis to skeletal nodes and brain.</i><br>(A) <i>lung with metastasis to skeletal nodes and brain.</i><br>(B) DUE TO<br>(C) |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><i>Four months</i>  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |  |                                    |   |   |
| 19A. DATE OF OPERATION<br><i>0</i>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No)   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                              |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-7 1965</i> to <i>4-11 1965</i> , that (I) (we) last saw the deceased alive on <i>4-11 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                            |                     |  |                                    |   |   |
| 23A. SIGNATURE<br><i>Thomas Paul Bigbee</i> M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |                     |  |                                    | 23B. DATE SIGNED<br><i>4-11-65</i>  |   |
| 23C. PHYSICIAN'S NAME (Type)  |                     |  |                                    | 23D. ADDRESS<br>M.D.  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                     | 24B. DATE<br><i>4 15 65</i>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><i>Cedar Hill</i>   |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Brooklyn, A. A. Co. Md.</i>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 13 1965</i>  |                                    | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |   |
| 25C. FUNERAL DIRECTOR<br><i>Mc Gilly</i>  |                     | ADDRESS<br><i>130 E. Fort Ave</i>  |                                    |   |   |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  |  |  |  |  |                                  |  |
|---|--|--|--|--|--|--|--|----------------------------------|--|
| BIRTH NO.   |  | 65 3941  |  | CERTIFICATE OF DEATH   |  | Registered No.   |  | 65 3941                          |  |
| M.E. CASE NO.   |  |  |  | 1. NAME OF DECEASED  |  | 2. DATE AND HOUR OF DEATH  |  |                                  |  |
| (Type or Print)   |  |  |  | WILLIAM C. TOFFRY SR.  |  | 4-10-65  |  | 6 15 P.M.                        |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  | A. STATE   |  | B. COUNTY                        |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |  |  |  | LUTHERAN HOSPITAL OF MD  |  | MARYLAND   |  | BALTIMORE                        |  |
| 5. SEX  |  |  |  | 6. RACE  |  | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)  |  | 8. DATE OF BIRTH                 |  |
| M   |  |  |  | W  |  | MARRIED  |  | 6-7-1900                         |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY?     |  |
| Brewmaster  |  |  |  | Beer   |  | Russia   |  | U.S.A.                           |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) |  | 16. SOCIAL SECURITY NO.          |  |
| Woldemar Toffry   |  |  |  | Unknown  |  | No   |  | 214-01-7419                      |  |
| 17. INFORMANT   |  |  |  | ADDRESS  |  | 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| Laura M. Toffry   |  |  |  | 5526 Willys Ave.   |  | PULMONARY EDEMA  |  |                                  |  |
| 19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | 20. CAUSE OF DEATH   |  | ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE WITH CONGESTIVE HEART FAILURE                                   |  |                                  |  |
| II  |  |  |  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                       |  | DIABETES MELLITUS  |  |                                  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                                     |  |                                  |  |
| O   |  |  |  |  |  |  |  |                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |                                  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |                                  |  |
| (APPROX.)   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |  |  |  |  |                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4-10-65 to 4-10-65, that (I) (we) last saw the deceased alive on 4-10-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |  |  |                                  |  |
| 23A. SIGNATURE  |  |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED   |  |                                  |  |
| Jesus G. Santiano   |  |  |  |  |  | 4-10-65  |  |                                  |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |  |  | M.D. LUTHERAN HOSPITAL OF MD.  |  | 23D. ADDRESS   |  |                                  |  |
|   |  |  |  |  |  |  |  |                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY or CREMATORY   |  | 24D. LOCATION (City, town, or county) (State)  |  |                                  |  |
| Burial  |  | 4/14/65  |  | Meadowridge Cemetery   |  | Dorsey Maryland  |  |                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR  |  | ADDRESS  |  |                                  |  |
| APR 13 1965   |  | Robert E. Fawcett  |  | Charles E. Dr. 1328 Sulphur Sp. Rd.  |  |  |  |                                  |  |



1

65 3942

BALTIMORE CITY HEALTH DEPARTMENT

65 3942

BIRTH NO. MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

M.E. CASE NO.

1. NAME OF DECEASED (Type or Print) EDWARD E. SAPP

2. DATE AND HOUR PRONOUNCED DEAD 4/9/65 11:59 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 13-06

D. STREET ADDRESS (If rural, give location) 2300 Elm Ave

5. SEX male 6. RACE white 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED

8. DATE OF BIRTH JUN 28 1905 9. AGE (In years last birthday) 59

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE 10B. KIND OF BUSINESS OR INDUSTRY CONTINENTAL CAN 11. BIRTHPLACE (State or foreign country) MD.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME P 14. MOTHER'S MAIDEN NAME P

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service) NO 16. SOCIAL SECURITY NO. 215-01-6521 17. INFORMANT ADDRESS EMMA L. SAPP 3300 ELM AVE.

18. CAUSE OF DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease

II. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

III. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) no 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH. 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21F. HOW DID INJURY OCCUR?

22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Rudiger Breitenecker, M.D. CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER

DATE SIGNED 4/10/65

23A. BURIAL CREMATION, REMOVAL (Specify) 23B. DATE 23C. NAME of CEMETERY or CREMATORY 23D. LOCATION (City, town, or county) (State)

BURIAL 4/13/65 MORELAND PARK BALTO.

24A. DATE REC'D BY HEALTH DEPT. 24B. NAME OF REGISTRAR 24C. FUNERAL DIRECTOR ADDRESS

APR 13 1965 Robert E. Taylor 3617 Chestnut St

WALTER E. P. BING

1445 E. 10TH ST.

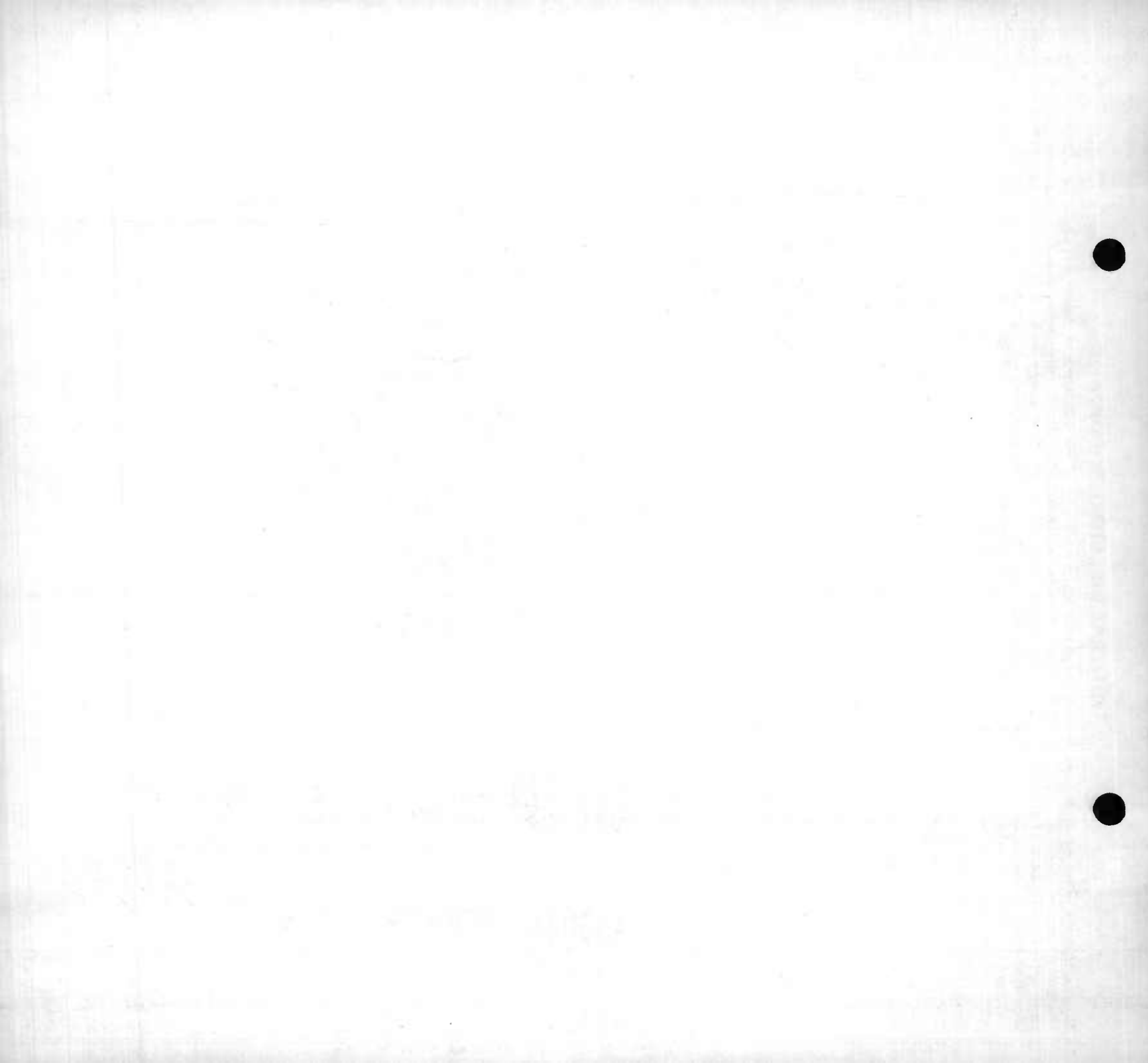
U.S.A.

NEW YORK

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |           |   |                          |  |                                    |
|---|-----------|---|--------------------------|--|------------------------------------|
| BIRTH NO. 65 3943   |           | BALTIMORE CITY HEALTH DEPARTMENT  |                          | CERTIFICATE OF DEATH X Registered No. 65 3943                            |                                    |
| M.E. CASE NO.   |           | 1. NAME OF DECEASED<br>(Type or Print) ADDIE F. HOLLAND   |                          | 2. DATE AND HOUR OF DEATH<br>4/9/65 16 45 M.                             |                                    |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><br>CARRISON NURSING HOME  |           | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE MD. B. COUNTY Balto.<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) BALTO. 53-00<br>D. STREET ADDRESS (If rural, give location) 2402 ALMA RD. |                          |  |                                    |
| 5. SEX F  | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED  | 8. DATE OF BIRTH 3/17/74 | 9. AGE (In years last birthday) 91                                       | 10. Under 1 Yr. Months Days 10 4 5 |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE.  |           | 10B. KIND OF BUSINESS OR INDUSTRY   |                          | 11. BIRTHPLACE (State or foreign country) V.A.                           |                                    |
| 13. FATHER'S NAME ?   |           | 14. MOTHER'S MAIDEN NAME ?  |                          | 12. CITIZEN OF WHAT COUNTRY?   |                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |           | 16. SOCIAL SECURITY NO.   |                          | 17. INFORMANT HARRY FLETCHER 2402 ALMA RD. ADDRESS                       |                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>420.1<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |           | CAUSE OF DEATH<br>(A) DUE TO Coronary Sclerosis<br>Congestive Heart Failure<br>(B) DUE TO Fallure in an an<br>interio selective<br>(C) Basis<br>Sensibility   |                          | INTERVAL BETWEEN ONSET AND DEATH   |                                    |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |           |   |                          |  |                                    |
| 19A. DATE OF OPERATION  |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                          | 20A. AUTOPSY? (Yes or No)  |                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |                                    |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)   |           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> At Work <input type="checkbox"/>  |                          | 21F. HOW DID INJURY OCCUR?   |                                    |
| 22. I certify that (I) (this hospital) attended the deceased from 1965 to Apr 5th 1965, that (I) (we) last saw the deceased alive on Apr 5th 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |           |   |                          |  |                                    |
| 23A. SIGNATURE M. Paul Byerly M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |           | 23B. DATE SIGNED 4/12/65  |                          | 23C. PHYSICIAN'S NAME (Type) M. Paul Byerly M.D.                         |                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL   |           | 24B. DATE 4/12/65   |                          | 24C. NAME OF CEMETERY or CREMATORY ST. MARYS                             |                                    |
| 24D. LOCATION (City, town, or county) BALTO.  |           | 24E. (State) MD.  |                          | 24F. 21212   |                                    |
| 25A. DATE REC'D BY HEALTH DEPT. APR 13 1965   |           | 25B. NAME OF REGISTRAR Robert E. Farber   |                          | 25C. FUNERAL DIRECTOR Paul E. Charovitz 3617 Chestnut Ave.               |                                    |

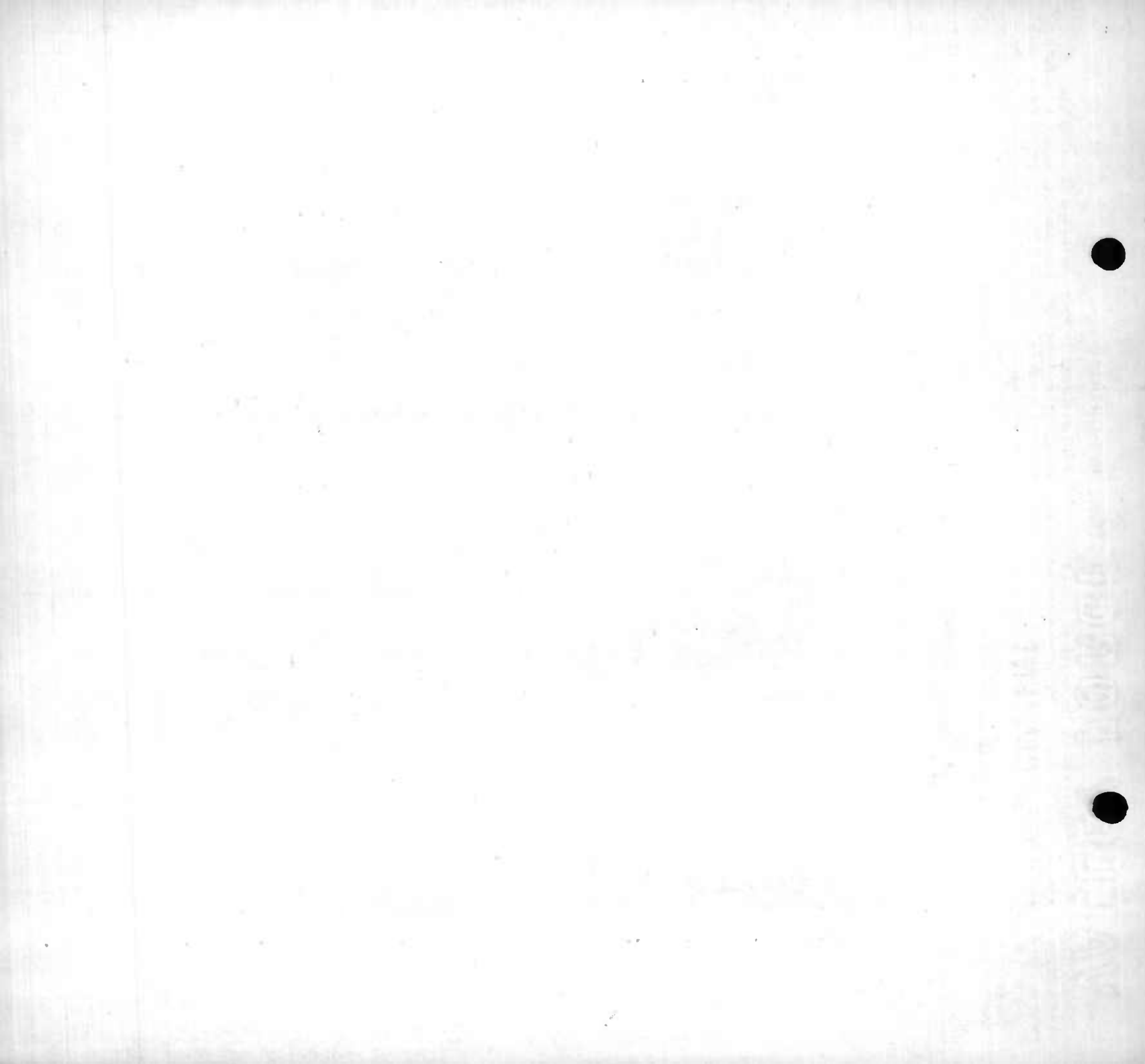




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

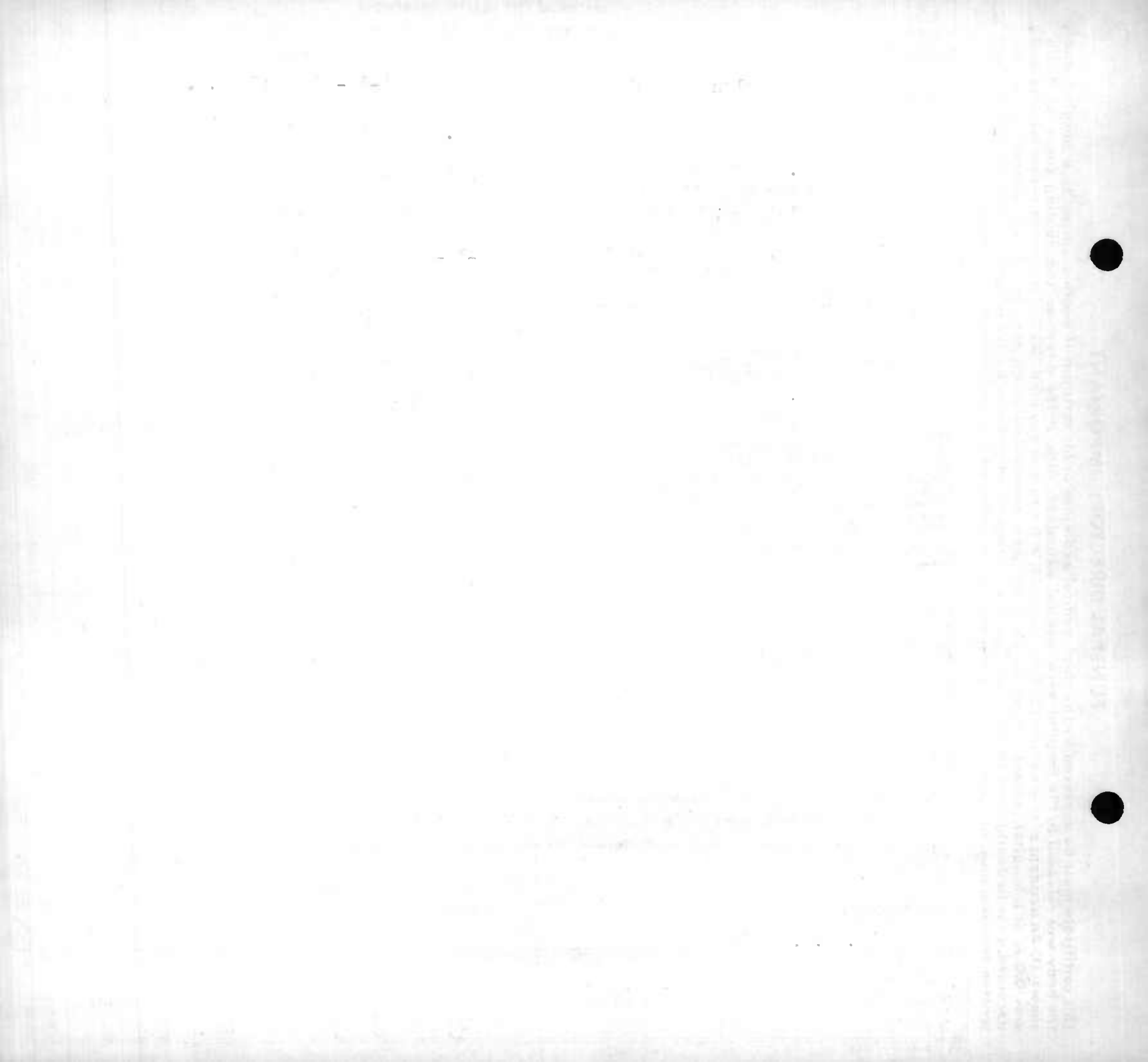
| BALTIMORE CITY HEALTH DEPARTMENT   |         |   |   | Registered No.   |  |
|--|---------|---|---|--|--|
| BIRTH NO.  |         | 65 3944   |   | 65 3944  |  |
| M.E. CASE NO.  |         |   |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |         |   | 2. DATE AND HOUR OF DEATH   |  |  |
| Martis, Kostas G.  |         |   | April 11 1965 5.05P M.  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |         |   | A. STATE B. COUNTY  |  |  |
| St. Joseph Hospital  |         |   | Maryland 9-08   |  |  |
|  |         |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |  |  |
|  |         |   | Baltimore 21218   |  |  |
|  |         |   | D. STREET ADDRESS (If rural, give location)   |  |  |
|  |         |   | 635 Walpert Ave.  |  |  |
| 5. SEX   | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                  | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| male   | white   | married   | Sept. 15 1891   | 73   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY   |   | 11. BIRTHPLACE (State or foreign country)                                |  |
| cook   |         | RESTURANT   |   | Turkey   |  |
| 13. FATHER'S NAME  |         |   | 14. MOTHER'S MAIDEN NAME  |  |  |
| George MARTIS  |         |   | UNKNOWN - CONDOLUS ZAFIRA   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         |   | 17. INFORMANT ADDRESS   |  |  |
|  |         |   | 635 WALPERT AVE.  |  |  |
|  |         |   | MRS. DELTA V. MARTIS  |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |         |   | CAUSE OF DEATH  |  |  |
| 420.11   |         |   | Acute Diaphragmatic Myocardial Infarction   |  |  |
| ANTECEDENT CAUSES  |         |   | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         |   |   |  |  |
| II   |         |   |   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |         |   |   |  |  |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |  |
|  |         |   |   | no   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |         |   |   |  |  |
| 21D. TIME OF INJURY (APPROX.)  |         | 21E. INJURY OCCURRED  |   | 21F. HOW DID INJURY OCCUR?   |  |
|  |         | While At Work <input type="checkbox"/> At Work <input type="checkbox"/>                 |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from April 10 19 65 to April 11 19 65, that (I) (we) last saw the deceased alive on April 11 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |   |   |  |  |
| 23A. SIGNATURE   |         |   | 23B. DATE SIGNED  |  |  |
| Anastacio E. Subong Jr.  |         |   | April 11 1965   |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |         |   | 23D. ADDRESS  |  |  |
|  |         |   | 1400 N. Caroline St. Balto. 21213 Md.   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE   |   | 24C. NAME of CEMETERY or CREMATORY                                       |  |
| Burial   |         | April 14, 1965  |   | GREEK CEM. BALTO. MD.  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR  |   | 25C. FUNERAL DIRECTOR ADDRESS  |  |
| APR 13 1965  |         | G. TRUMAN SCHWAB  |   | 3512 Frederick Ave. (29)   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |                                     | Registered No. _____   |   |
|---|-------------------------|--|-------------------------------------|--|---|
| BIRTH NO. _____   |                         | M.E. CASE NO. _____  |                                     | 1. NAME OF DECEASED<br>(Type or Print) <b>Helen Margerites</b>           |   |
| 2. DATE AND HOUR OF DEATH<br><b>4-10-65 8:50 A.M.</b>   |                         | 3. PLACE OF DEATH <b>BALTIMORE, MARYLAND</b>   |                                     |  |   |
| 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore City</b>  |                         | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Agnes Hospital<br/>Caton and Wilkens Avenue<br/>Baltimore, Maryland</b> |                                     |  |   |
| 6. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>   |                         | 7. STREET ADDRESS (If rural, give location)<br><b>609 Wellesley Street #29</b>   |                                     |  |   |
| 8. SEX<br><b>Female</b>   | 9. RACE<br><b>Cauc.</b> | 10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Married</b>  | 11. DATE OF BIRTH<br><b>7-17-07</b> | 12. AGE (In years last birthday)<br><b>57</b>                            | 13. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Proprietor</b>   |                         | 15. KIND OF BUSINESS OR INDUSTRY<br><b>Resturant</b>   |                                     | 16. BIRTHPLACE (State or foreign country)<br><b>PENNSYLVANIA</b>         |   |
| 17. FATHER'S NAME<br><b>John ZAREVA</b>   |                         | 18. MOTHER'S MAIDEN NAME<br><b>UNKNOWN</b>   |                                     |  |   |
| 19. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 20. SOCIAL SECURITY NO. _____  |                                     | 21. INFORMANT<br><b>Mrs. Peggy KOENIG</b>                                |   |
| 22. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Metastatic Carcinoma of liver, undifferentiated</b>   |                         | 23. CAUSE OF DEATH<br>(A) DUE TO _____<br>(B) DUE TO _____<br>(C) _____  |                                     | 24. INTERVAL BETWEEN ONSET AND DEATH<br><b>8 mo</b>                      |   |
| 25. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>   |                         | 26. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                                     |  |   |
| 27. MEDICAL CERTIFICATION<br>19A. DATE OF OPERATION<br><b>D</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                                   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Aug 22 1964</b> to <b>4-10-1965</b> , that (I) (we) last saw the deceased alive on <b>March 29 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |                         |  |                                     |  |   |
| 23A. SIGNATURE<br><b>S.G. Sullivan</b>  |                         | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |                                     | 23B. DATE SIGNED<br><b>4-12-65</b>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. S.G. Sullivan</b>  |                         | 23D. ADDRESS<br><b>11295 Paul St Baltimore 2 Md.</b>   |                                     |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4/13/65</b>  |                                     | 24C. NAME of CEMETERY or CREMATORY<br><b>Greek Cem.</b>                  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. Md.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                                     |  |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Sullivan</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>GEORGE A. Schaub</b>   |                                     | ADDRESS<br><b>3512 Fred. Ave.</b>  |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |  | Registered No. <span style="float: right;">65 3946</span>                |   |
|---|-------------------------|---|--|--|---|
| BIRTH NO. <span style="float: left;">65-09252</span> <span style="float: left;">65 3946</span> <span style="float: right;">CERTIFICATE OF DEATH</span>  |                         |   |  |  |   |
| M.E. CASE NO.   |                         |   | 2. DATE AND HOUR OF DEATH  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Baby LANE</i>   |                         |   | 4-10-65 — 8PM  |  |   |
| 3. PLACE OF DEATH IN <i>BALTIMORE, MARYLAND</i>   |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i> |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Bon Secours</i>   |                         |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>  |  |   |
|   |                         |   | D. STREET ADDRESS (If rural, give location)<br><i>1316 Ingleside Ave</i>   |  |   |
| 5. SEX<br><i>Male</i>   | 6. RACE<br><i>white</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>Single</i>                                 | 8. DATE OF BIRTH<br><i>4-10-65</i>   | 9. AGE (In years last birthday)<br><i>14 mos</i>                         | 10. If Under 1 Yr. Months: Days: Hours: Min.<br><i>15</i> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>             |   |
| 12. CITIZEN OF WHAT COUNTRY?  |                         | 13. FATHER'S NAME<br><i>Hubert Lanes</i>  |  | 14. MOTHER'S MAIDEN NAME<br><i>Mildred Burns</i>                         |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><i>Hospital Recd - Baltimore Md</i>             |   |
| 18. <i>776 X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>immaturity</i>   |                         |   | CAUSE OF DEATH   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |   | (A) DUE TO   |  |   |
|   |                         |   | (B) DUE TO   |  |   |
|   |                         |   | (C) DUE TO   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |   | INTERVAL BETWEEN ONSET AND DEATH   |  |   |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-10 1965</i> to <i>4-10 1965</i> , that (I) (we) last saw the deceased alive on <i>4-10 1965</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |  |  |   |
| 23A. SIGNATURE<br><i>James [Signature]</i>  |                         |   |  | 23B. DATE SIGNED<br><i>4/10/65</i>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)  |                         |   |  | 23D. ADDRESS<br><i>Bon Secours Hos</i>                                   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                         | 24B. DATE<br><i>4/12/65</i>   |  | 24C. NAME of CEMETERY or CREMATORY<br><i>Horace Park Cem</i>             |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore Md</i>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 13 1965</i>   |  | 25B. NAME OF REGISTRAR<br><i>John P. Kenny</i>                           |   |
| 25C. FUNERAL DIRECTOR<br><i>John P. Kenny</i>   |                         | 25D. ADDRESS<br><i>John P. Kenny Funeral Home</i>   |  |  |   |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/65

Letter from Johns Hopkins Hospital  
4-19-65 M.H.



BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

5. SEX

female

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

8. DATE OF BIRTH

July 28 62

9. AGE (In years  
last birthday)

2

11. BIRTHPLACE (State or foreign country)

Berkeley Springs w.VA

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

Walter Beddow

14. MOTHER'S MAIDEN NAME

Nancey Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Interstitial pneumonitis  
DUE TO (Hemophilus influenzae)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

W.U. Spitz, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☒

DATE SIGNED

4/9/65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-12-65

23C. NAME of CEMETERY or CREMATORY

Greenway Cemetery

23D. LOCATION

(City, town, or county)

(State)

Berkeley Springs W.VA

24A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

24B. NAME OF REGISTRAR

E. Farley M.D.

24C. FUNERAL DIRECTOR

Walter Dabrowski 1005 Dunsell ave.

ADDRESS

VALLEY FORT

PAID BY

OS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3949   |                     |   |                                   | BALTIMORE CITY HEALTH DEPARTMENT   |                              | Registered No. 65 3949  |  |
|---|---------------------|---|-----------------------------------|--|------------------------------|---|--|
| M.E. CASE NO.   |                     |   |                                   | CERTIFICATE OF DEATH   |                              |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Louvenia C. Morris</b>  |                     |   |                                   | 2. DATE AND HOUR OF DEATH<br><b>April 9 1965 1 530 A.M.</b>  |                              |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                     |   |                                   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                              |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |                     | (If not in hospital or institution, give street address or location)                                      |                                   | A. STATE<br><b>Maryland</b>  |                              | B. COUNTY<br><b>26-09</b>   |  |
| 905 S. Fagley St  |                     |   |                                   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b>  |                              |   |  |
| D. STREET ADDRESS (If rural, give location)<br><b>905 S. Fagley St</b>  |                     |   |                                   |  |                              |   |  |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>-----</b>                                  | 8. DATE OF BIRTH<br><b>8-1-93</b> | 9. AGE (In years last birthday)<br><b>72</b>   | If Under 1 Yr. Months: Days: | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                   | 11. BIRTHPLACE (State or foreign country)<br><b>Green County VA</b>  |                              | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>Scott Morris</b>  |                     |   |                                   | 14. MOTHER'S MAIDEN NAME<br><b>Mary Shiflett</b>   |                              |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                     | 16. SOCIAL SECURITY NO.<br><b>220243555</b>   |                                   | 17. INFORMANT  |                              | ADDRESS   |  |
| 18. <b>420.11</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   |                                   | CAUSE OF DEATH<br>(A) <b>Coronary Thrombosis</b><br>DUE TO<br>(B) <b>Arteriosclerotic Heart Disease</b><br>DUE TO<br>(C) <b>Remote Rt Hemiplegia</b> |                              | INTERVAL BETWEEN ONSET AND DEATH                                      |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |   |                                   |  |                              |   |  |
| 19A. DATE OF OPERATION  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                   | 20A. AUTOPSY? (Yes or No)  |                              | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                                   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                              |   |  |
| 21D. TIME OF INJURY (APPROX.)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                   | 21F. HOW DID INJURY OCCUR?   |                              |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>June 19 64</b> to <b>4/9 19 65</b> , that (I) (we) last saw the deceased alive on <b>4/7 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) <b>(did)</b> (did not) view the body after death.               |                     |   |                                   |  |                              |   |  |
| 23A. SIGNATURE<br><b>Robert C. Duvall</b> M.D.  |                     |   |                                   | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>                      |                              | 23B. DATE SIGNED<br><b>4/10/65</b>                                    |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROBERT C. DUVAL</b> M.D.   |                     |   |                                   | 23D. ADDRESS<br><b>101 W. READ ST. BALTO.</b>  |                              |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>4-13-65</b>   |                                   | 24C. NAME of CEMETERY or CREMATORY<br><b>Oak Lawn</b>  |                              | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                     | 25B. NAME OF REGISTRAR<br><b>R. E. Fawcett</b>  |                                   | 25C. FUNERAL DIRECTOR<br><b>Walter Dabrowski</b>   |                              | ADDRESS<br><b>1005 DUNDALK AVE</b>                                    |  |

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Francis C. Butler

1871

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                     |   |                                     |   |  |
|---|---------------------|---|-------------------------------------|---|--|
| BIRTH NO. 65 3950   |                     | BALTIMORE CITY HEALTH DEPARTMENT  |                                     | Registered No. 65 3950  |  |
| M.E. CASE NO.   |                     | CERTIFICATE OF DEATH  |                                     | X   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Linthicum Mrs. Mary Delmah</i>  |                     | 2. DATE AND HOUR OF DEATH<br><i>4-13-65</i> 1 P.M.  |                                     |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><i>Bow Secours Hospital</i>  |                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Maryland</i> B. COUNTY <i>Anne Arundel</i><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Linthicum Heights</i> 52-00<br>D. STREET ADDRESS (If rural, give location)<br><i>102 West Maple Road</i> |                                     |   |  |
| 5. SEX<br><i>F</i>  | 6. RACE<br><i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><i>Widowed</i>  | 8. DATE OF BIRTH<br><i>11/15/40</i> | 9. AGE (In years last birthday)<br><i>24</i>                                      | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>New York</i>                      |  |
| 13. FATHER'S NAME<br><i>John T. Brown</i>   |                     | 14. MOTHER'S MAIDEN NAME<br><i>Lucretia Linthicum</i>   |                                     | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>   |                     | 16. SOCIAL SECURITY NO.<br><i>None</i>  |                                     | 17. INFORMANT<br><i>Mr. Sweetser Linthicum Linthicum Heights, Md.</i>             |  |
| 18. <i>260X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><i>Hypertensive</i><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>Arteriosclerotic Cardiovascular Disease</i><br><i>Chronic Congestive Heart Failure</i><br><i>Diabetes mellitus</i> |                     | CAUSE OF DEATH<br>(A) <i>Arteriosclerotic Cardiovascular Disease</i><br>DUE TO<br>(B) <i>Chronic Congestive Heart Failure</i><br>DUE TO<br>(C) <i>Diabetes mellitus</i>   |                                     | INTERVAL BETWEEN ONSET AND DEATH<br><i>years</i><br><i>months</i><br><i>years</i> |  |
| MEDICAL CERTIFICATION   |                     |   |                                     |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                     |   |                                     |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><i>No</i>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)          |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that <del>(H)</del> (this hospital) attended the deceased from <i>April 7</i> 19 <i>65</i> to <i>April 13</i> 19 <i>65</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>April 12</i> 19 <i>65</i> and that in <del>(my)</del> <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>(did not)</del> view the body after death.   |                     |   |                                     |   |  |
| 23A. SIGNATURE<br><i>Francisco Baltazar Jr.</i>   |                     |   |                                     | 23B. DATE SIGNED<br><i>April 13, 1965</i>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>Francisco Baltazar Jr.</i>   |                     | 23D. ADDRESS<br><i>M.D. Baltimore, Md. 17</i>   |                                     |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                     | 24B. DATE<br><i>4/16/1965</i>   |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><i>Cedar Hill Cemetery</i>                  |  |
| 24D. LOCATION (City, town, or county)<br><i>Anne Arundel County, Md.</i>  |                     | 24E. ADDRESS<br><i>Baltimore, Md. 17</i>  |                                     |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 13 1965</i>   |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. [illegible]</i>  |                                     | 25C. FUNERAL DIRECTOR<br><i>Wm. J. [illegible]</i>                                |  |

Superintendent

Respectfully,  
Your obedient servant,  
Francis B. Patterson

Francis B. Patterson  
Superintendent

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. 65 3951

BIRTH NO.

65 3951

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Clarabelle Taylor

2. DATE AND HOUR OF DEATH

April 12, 1965

M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution, give street  
address or location)

4 Longwood Road  
Baltimore, Maryland 21210

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4 Longwood Road 21210

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Widowed

8. DATE OF BIRTH

Oct. 19, 1875

9. AGE (In years  
last birthday)

89

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

Baltimore, Maryland

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

John Smith Ditch

14. MOTHER'S MAIDEN NAME

Florence J. Moore

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

None

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Mr. Winfield S. Ditch, Jr. Balto., Md. 10

ADDRESS  
4 Longwood Road

18. 626 X I

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) Malnutrition  
DUE TO Chronic recto-vaginal-  
vesical fistula 7 yrs.

(B) DUE TO

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

Malfunctioning Colostomy

7 yrs.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notably medical examiner)

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED  
While At Work ☐ Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 7-20 1963 to 4-12 1965,  
that (I) (we) last saw the deceased alive on 3-31 1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

W. P. Benson, Jr.

M.D.

Attending  
Phys. ☒

Med.  
Director ☐

Staff  
Phys. ☐

23B. DATE SIGNED

4-12-65

23C. PHYSICIAN'S  
NAME (Type)

WILLIAM P. BENSON, JR.

M.D.

23D. ADDRESS

3506 N. CALVERT BALTIMORE, MD.

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

4/14/1965

24C. NAME of CEMETERY or CREMATORY

Loudon Park Cemetery

24D. LOCATION

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

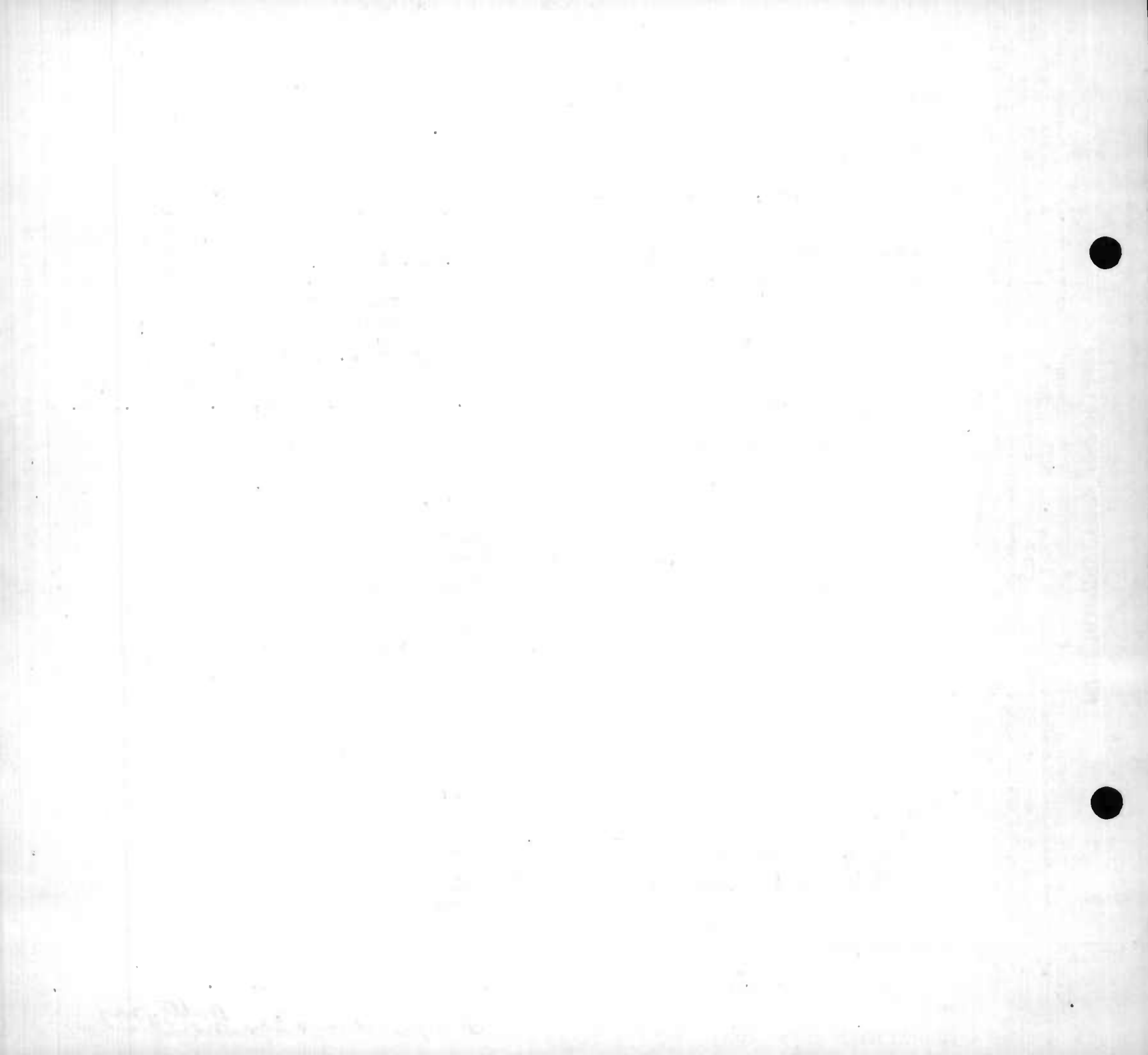
25B. NAME OF REGISTRAR

Robert E. Benson

25C. FUNERAL DIRECTOR

W. P. Benson & Sons Balto. Md. 21217  
North Ave.

ADDRESS

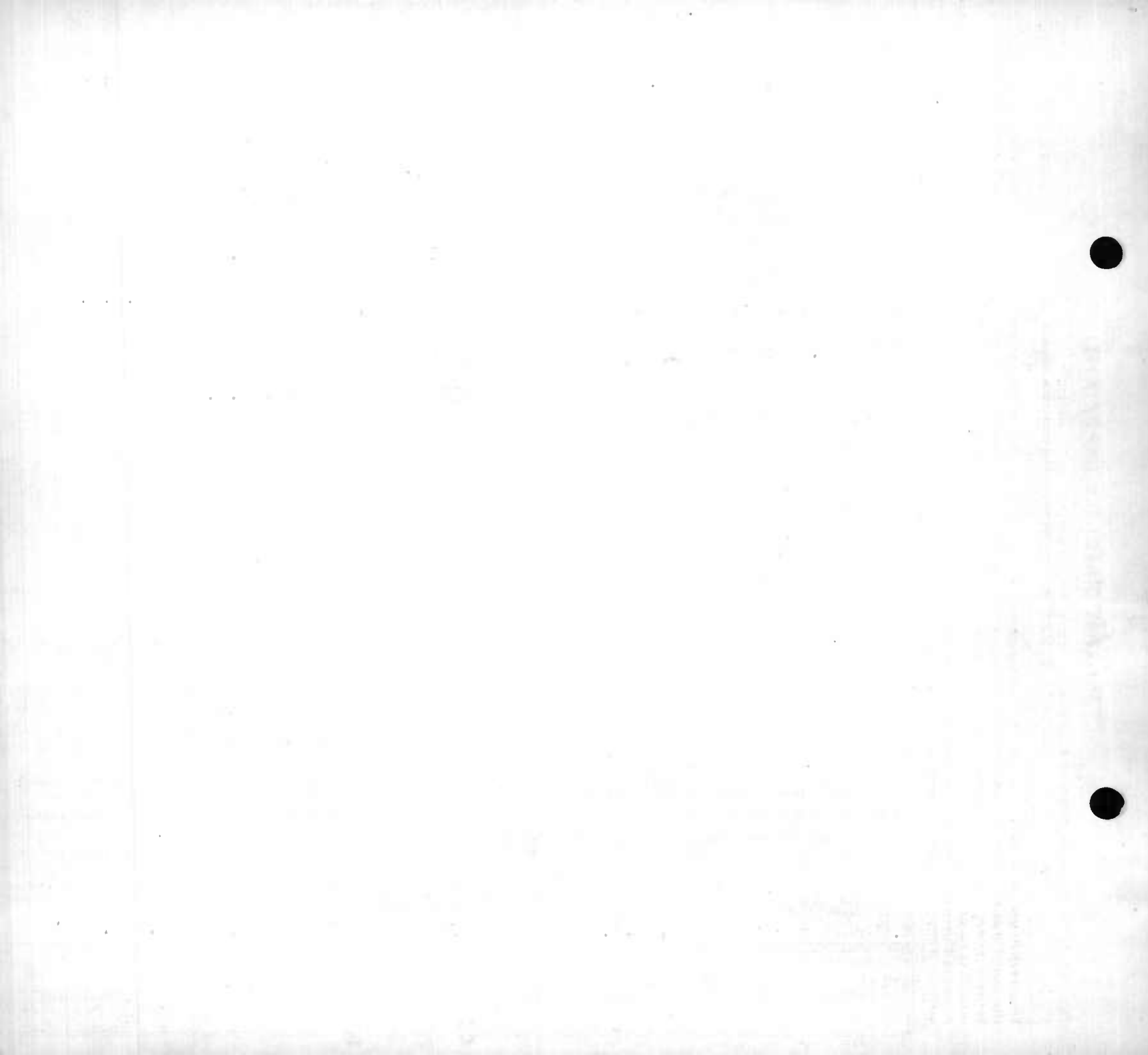




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                             |  |                                       |  |  |   |   |   |  | Registered No. 65 3952  |  |
|--|-----------------------------|--|---------------------------------------|--|--|---|---|---|--|---|--|
| BIRTH NO. 65 3952  |                             | <b>CERTIFICATE OF DEATH</b>  |                                       |  |  |   |   |   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>PARKER, EDWARD G.</b>  |                             |  |                                       |  |  | 2. DATE AND HOUR OF DEATH<br><b>4/12/1965 8:40 AM.</b>  |   |   |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>KESWICK</b>  |                             |  |                                       |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>KESWICK</b><br>B. COUNTY <b>BALTO. MARYLAND 21211</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTO. MARYLAND 21211</b><br>D. STREET ADDRESS (If rural, give location)<br><b>700 West 40th Street</b> |   |   |  |   |  |
| 5. SEX<br><b>MALE</b>  | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>WIDOWED</b>               | 8. DATE OF BIRTH<br><b>12/12/1875</b> | 9. AGE (In years lost birthday)<br><b>89 yrs.</b>                        | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Insurance Underwriter</b> |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b> |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                      |   |  |
| 13. FATHER'S NAME<br><b>William H. Parker</b>  |                             |  |                                       |  |  | 14. MOTHER'S MAIDEN NAME<br><b>Emma Phillips</b>  |   |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                             |  |                                       |  |  | 16. SOCIAL SECURITY NO.   |   | 17. INFORMANT<br><b>Elizabeth Merrick, R.N.</b>                   |  | ADDRESS<br><b>Keswick</b>   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>450.0 I</b><br><b>Anterobronchitis (generalized)</b>  |                             |  |                                       |  |  | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) DUE TO  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>8 years</b>                          |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                             |  |                                       |  |  |   |   |   |  |   |  |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                             |  |                                       |  |  |   |   |   |  |   |  |
| 19A. DATE OF OPERATION   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                       | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |   |   |   |  |   |  |
| 21D. TIME OF INJURY (APPROX.)  |                             | 21E. INJURY OCCURRED   |                                       | 21F. HOW DID INJURY OCCUR?   |  |   |   |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>February 24 1950</b> to <b>April 12 1965</b> , that (I) (we) last saw the deceased alive on <b>April 10 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |  |                                       |  |  |   |   |   |  |   |  |
| 23A. SIGNATURE<br><b>W. Grafton Hersperger</b> M.D.  |                             |  |                                       |  |  | 23B. DATE SIGNED<br><b>April 12, 1965</b>   |   |   | 23C. PHYSICIAN'S NAME (Type)<br><b>W. Grafton Hersperger, M.D.</b> |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                             |  |                                       |  |  | 24B. DATE<br><b>4/15/1965</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Loudon Park Cemetery</b> |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                             |  |                                       | 25B. NAME OF REGISTRAR<br><b>Robert S. [unclear]</b>                     |  |   |   | 25C. FUNERAL DIRECTOR<br><b>Wm. J. [unclear]</b>                  |  |   |  |



BIRTH NO. 65 3953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No. 65 3953

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

FAY BARKER

2. DATE AND HOUR PRONOUNCED DEAD

April 12, 1965 1:07 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Franklin Square

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

303 Wyman Park Drive

21211

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

May 3, 1921

9. AGE (In years  
last birthday)

43

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Painter

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Georgia

12. CITIZEN OF  
WHAT COUNTRY?

13. FATHER'S NAME

W. I. Barker

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

254-20-3459

17. INFORMANT

Mrs. Inez Barker 303 Wyman Park Drive  
Baltimore, Maryland 21211

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

Arteriosclerotic cardiovascular disease  
(A) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)21D. TIME OF INJURY  
(APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenacker

CHIEF MEDICAL EXAMINER ☐M.D. ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4-13-6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Removal

23B. DATE

4/13/1965

23C. NAME OF CEMETERY or CREMATORY

Lafayette Memorial Cemetery Fayetteville, N. C.

23D. LOCATION

(City, town, or county)

(State)

24A. DATE REC'D BY HEALTH DEPT.

APR 13 1965

24B. NAME OF REGISTRAR

Robert E. Farley, M.D.

24C. FUNERAL DIRECTOR

Wm. T. Johnson, Jr. Balto., Md. 21217

ADDRESS

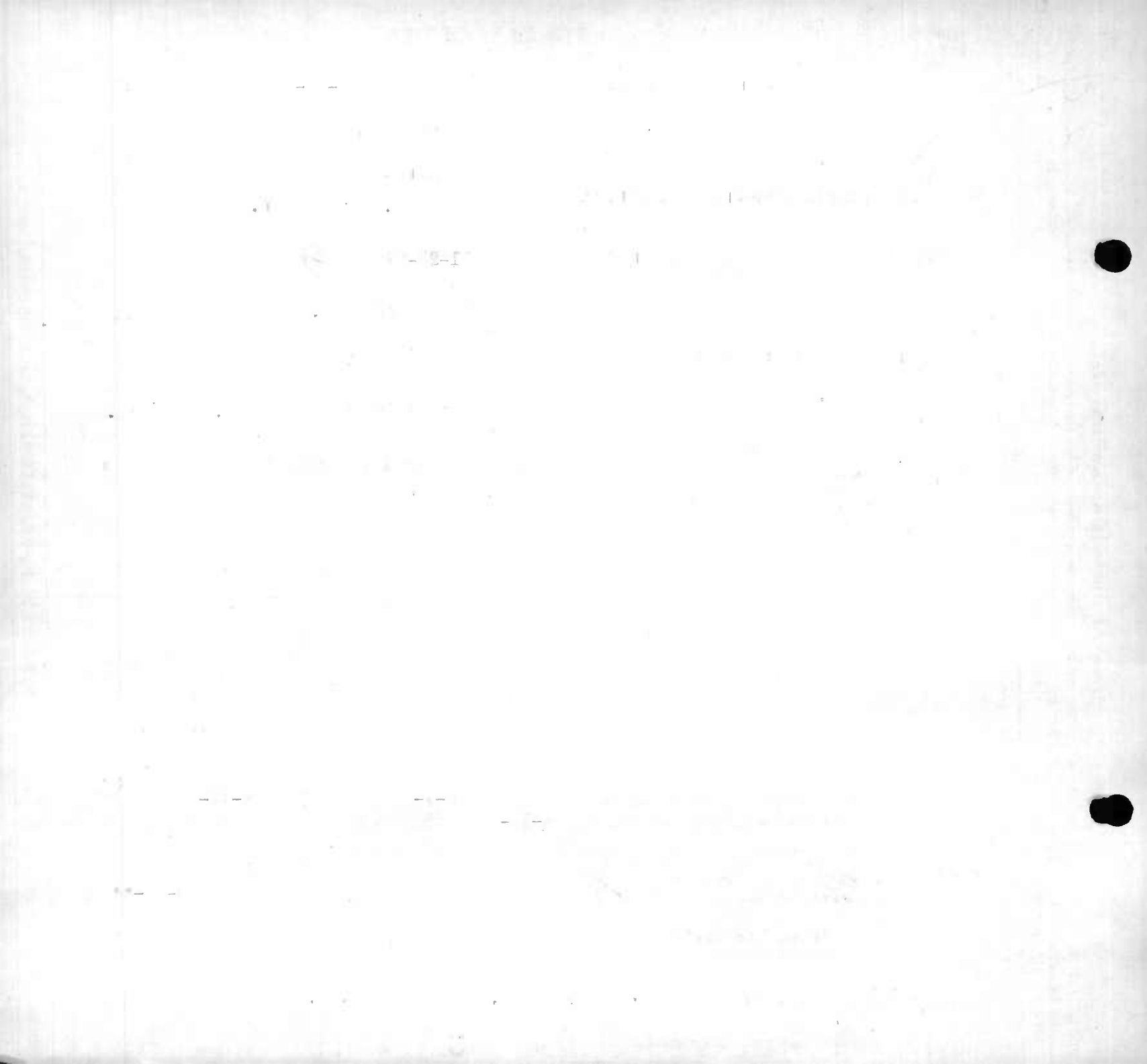
VALLEY FORGE

WAS SENT IT

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |  |                                     |  |  |
|---|-------------------------|--|-------------------------------------|--|--|
| BIRTH NO.<br>65 3954  |                         | BALTIMORE CITY HEALTH DEPARTMENT   |                                     | Registered No. 65 3954   |  |
| M.E. CASE NO.   |                         | CERTIFICATE OF DEATH   |                                     |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>LOTTIE JENNINGS</b>  |                         | 2. DATE AND HOUR OF DEATH<br><b>4-11-65 7:37 P M.</b>  |                                     |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>THE JOHNS HOPKINS HOSPITAL</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND,</b> B. COUNTY <b>7-04</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1742 E. EAGER ST.</b> |                                     |  |  |
| 5. SEX<br><b>FEMALE</b>   | 6. RACE<br><b>NEGRO</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>   | 8. DATE OF BIRTH<br><b>11-28-07</b> | 9. AGE (In years lost birthday)<br><b>57</b>                             | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Prince George Va.</b>    |  |
| 13. FATHER'S NAME<br><b>RICHARD CLAIBORNE</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Charity ?</b>   |                                     | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.  |                                     | 17. INFORMANT ADDRESS<br><b>Dorsey Jennings 1742 E. Eager St.</b>        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>331X I</b>   |                         | CAUSE OF DEATH<br>(A) <b>Cerebral vascular accident</b><br>DUE TO<br>(B)<br>DUE TO<br>(C)<br>INTERVAL BETWEEN ONSET AND DEATH<br><b>2 days</b>   |                                     |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |  |                                     |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |                                     |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-9-19 65</b> to <b>4-11-19 65</b> , that (I) (we) last saw the deceased alive on <b>4-11-19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                     |  |  |
| 23A. SIGNATURE<br><b>Bruce Lee Evatt</b>  |                         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                                     | 23B. DATE SIGNED<br><b>4-11-65</b>                                       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Bruce Lee Evatt</b>  |                         | 23D. ADDRESS<br><b>Johns Hopkins Hosp. Balt 5 Md</b>   |                                     |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4/15/65</b>  |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Calvary Cem.</b>            |  |
| 24D. LOCATION<br><b>A. A. County</b>  |                         | 24E. ADDRESS<br><b>1129 N. Calhoun St.</b>   |                                     |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>VS 150-REV. 1/1/65</b>  |                                     | 25C. FUNERAL DIRECTOR<br><b>VS 150-REV. 1/1/65</b>                       |  |



# FUNERAL DIRECTOR: IMPORTANT

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| BIRTH NO. 6 65 3955  |                         | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | Registered No. 65 3955   |   |
|--|-------------------------|--|--|--|---|
| M.E. CASE NO.<br>1. NAME OF DECEASED<br>(Type or Print) <b>THOMAS, SUSAN RACHAEL</b>   |                         |  | 2. DATE AND HOUR OF DEATH<br><b>4-11-65 10:00A.</b>  |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><b>CERTIFICATE CORRECTED 4-14-65</b><br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST. AGNES HOSPITAL</b>  |                         |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>Balto</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>CATONSVILLE #07 53-00</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1155 GRANVILLE RD.</b> |  |   |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED<br><b>WIDOWED</b>  | 8. DATE OF BIRTH<br><b>4-2-98</b>  | 9. AGE (In years last birthday)<br><b>67</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>             |   |
| 13. FATHER'S NAME<br><b>DANIEL LEONARD</b>   |                         |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U S A</b>   |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         |  | 16. SOCIAL SECURITY NO.<br><b>217038284</b>  |  |   |
| 17. INFORMANT<br><b>Paul E. Thomas (husband)</b>   |                         |  | ST. AGNES HOSPITAL RECORDS<br>WILKENS & CATON AVE., BALTO. # 29, MD.   |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>162.1 S.S.#217-01-8184</b>  |                         |  | CAUSE OF DEATH<br>(A) <b>Bronchogenic Carcinoma</b><br>(B) <b>Due to</b><br>(C) <b>Interval between onset and death</b>  |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |  |  |  |   |
| 19A. DATE OF OPERATION<br><b>4-11-65</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-3-1965</b> to <b>4-11-1965</b> , that (I) (we) last saw the deceased alive on <b>4-11-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |  |  |   |
| 23A. SIGNATURE<br><i>Richard J. Kelly</i>  |                         |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED<br><b>11/4/65</b>                        |
| 23C. PHYSICIAN'S NAME (Type)   |                         |  | 23D. ADDRESS<br><b>ST. AGNES HOSPITAL</b>  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>  |                         | 24B. DATE<br><b>4/14/65</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Lorraine Park</b>               |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. 7, Md.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |  |  |   |
| 25B. NAME OF REGISTRAR<br><b>Witzke F.D.</b>   |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>4101 Edmondson Ave</b>   |  |  |   |







# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                     |   |                                    |   |  |
|--|---------------------|---|------------------------------------|---|--|
| BIRTH NO. <u>3</u> <u>65 3956</u>  |                     | BALTIMORE CITY HEALTH DEPARTMENT  |                                    | Registered No. <u>65 3956</u>   |  |
| M.E. CASE NO.  |                     | CERTIFICATE OF DEATH  |                                    |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>LILLIAN ELIZABETH BRAUNING</u>   |                     | 2. DATE AND HOUR OF DEATH<br><u>5:30 AM - APRIL 9, 1965</u> M.  |                                    |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |                                    |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>UNIVERSITY Hospital</u><br>(If not in hospital or institution, give street address or location)   |                     | A. STATE <u>MD.</u><br>B. COUNTY <u>BALTO</u>   |                                    |   |  |
|  |                     | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>ELKRIDGE</u> <u>53-00</u>                                   |                                    |   |  |
|  |                     | D. STREET ADDRESS (If rural, give location)<br><u>5013 E. SHEET</u>   |                                    |   |  |
| 5. SEX<br><u>F</u>   | 6. RACE<br><u>W</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><u>WIDOW</u>  | 8. DATE OF BIRTH<br><u>9/26/06</u> | 9. AGE (In years lost birthday)<br><u>58</u>  | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>H.W.</u>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Own Home</u>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>MD</u>                                    |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>   |                     |   |                                    |   |  |
| 13. FATHER'S NAME<br><u>William Stewart</u>  |                     | 14. MOTHER'S MAIDEN NAME<br><u>Fredricka Burgraff</u>   |                                    |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                     | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT (daughter) <u>Glenburne d</u><br><u>Thelaine Kroedel, 305 Cathedral Pla</u> |  |
| 18. <u>420.1 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     | CAUSE OF DEATH<br>(A) <u>Myocardial Infarction</u><br>DUE TO<br>(B) <u>Atherosclerotic Cardiovascular</u><br>DUE TO<br>(C) <u>disease</u> |                                    | INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><u>Duodenal Ulcer</u>  |                     |   |                                    |   |  |
| 19A. DATE OF OPERATION<br><u>2</u>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                 |                                    | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that <u>she</u> (this hospital) attended the deceased from <u>3/16/65</u> to <u>4/9/65</u> that (I) <u>we</u> last saw the deceased alive on <u>4/9</u> 19 <u>65</u> and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (If <u>we</u> (did) (did not) view the body after death.  |                     |   |                                    |   |  |
| 23A. SIGNATURE<br><u>Francine Camitta</u>  |                     | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>      |                                    | 23B. DATE SIGNED<br><u>4/9/65</u>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Francine Camitta</u>  |                     | 23D. ADDRESS<br><u>University Hospital</u>  |                                    |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                     | 24B. DATE<br><u>4/12/65</u>   |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><u>Good Shepherd Cemetery</u>                       |  |
|  |                     | 24D. LOCATION (City, town, or county) (State)<br><u>Howard Co. Md.</u>  |                                    |   |  |
| 25A. DATE REC'D. BY HEALTH DEPT.<br><u>APR 13 1965</u>   |                     | 25B. NAME OF REGISTRAR<br><u>Robert E. Stachurski</u>   |                                    | 25C. FUNERAL DIRECTOR<br><u>Witzke F.D. 4101 Edmondson Ave</u>                            |  |

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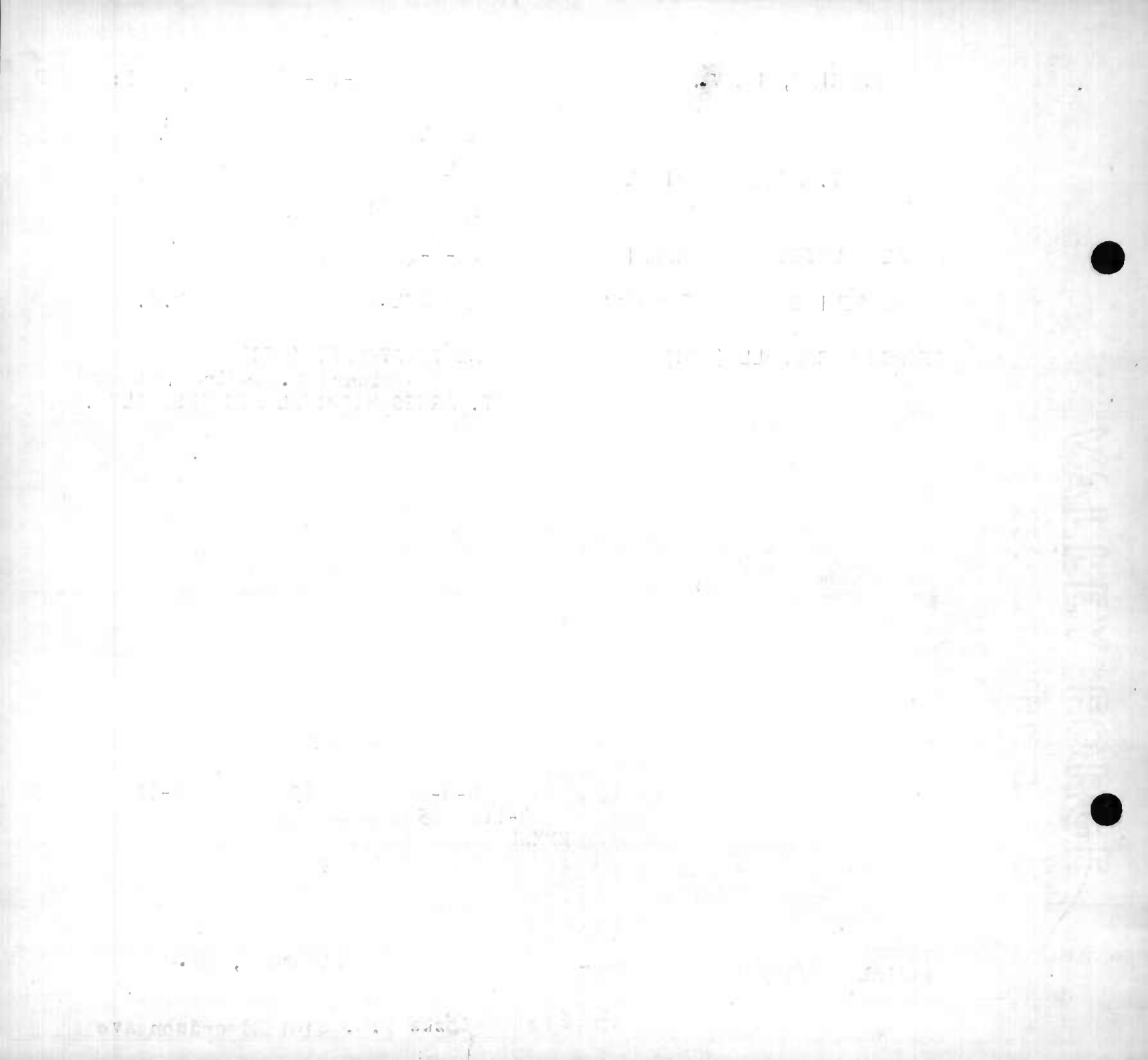
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

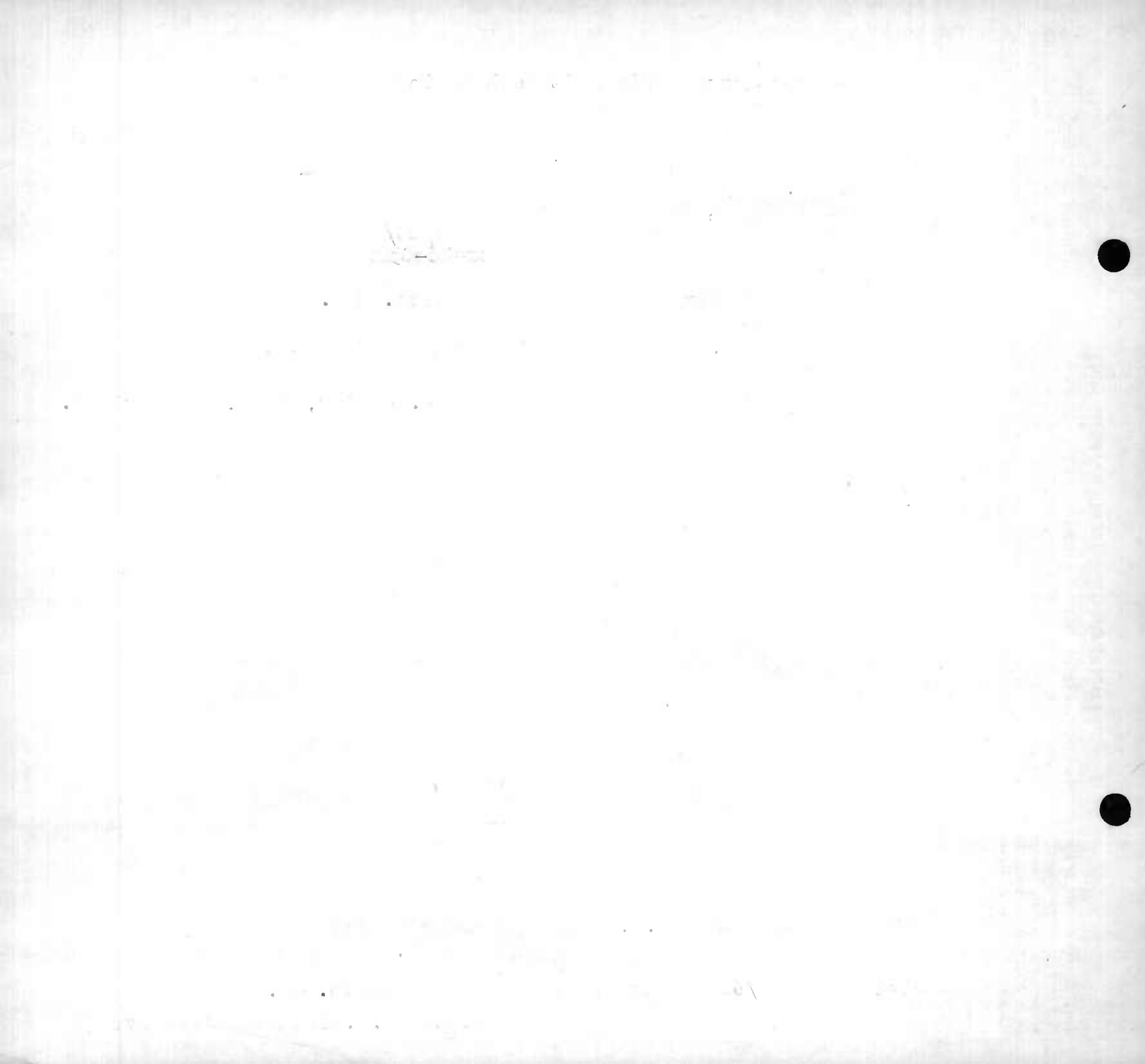
|  |                         |   |   |  |  |
|--|-------------------------|---|---|--|--|
| BIRTH NO. <b>5</b> <b>65 3957</b>  |                         | <b>CERTIFICATE OF DEATH</b>   |   | Registered No. <b>65 3957</b>  |  |
| M.E. CASE NO.  |                         |   | 1. NAME OF DECEASED<br>(Type or Print) <b>HAWKINS, IDAV.</b>  |  |  |
| 2. DATE AND HOUR OF DEATH<br><b>4-11-65</b> <b>3:30</b> P.M.   |                         |   | 3. PLACE OF DEATH IN BALTIMORE, MAR: <b>D</b>   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST. AGNES HOSPITAL</b>  |                         |   | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>Balto</b> |  |  |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE 28</b>   |                         |   | D. STREET ADDRESS (If rural, give location)<br><b>13 S BEECHWOOD AVENUE</b>   |  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>                                | 8. DATE OF BIRTH<br><b>12-4-89</b>  | 9. AGE (In years lost birthday)<br><b>75</b>                             | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>             |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>  |                         |   | 13. FATHER'S NAME<br><b>GEORGE W CARROLL (DEC)</b>  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>ANNIE STEWART (DEC)</b>   |                         |   | 15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service)<br><b>NO</b>  |  |  |
| 16. SOCIAL SECURITY NO.  |                         |   | 17. INFORMANT <b>Edward S. Hawkins (husband)</b><br><b>ST. AGNES HOSPITAL RECORDS BALTO. 29, MD</b>   |  |  |
| 18. <b>331X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CVA</b>   |                         |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 week</b>   |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                         |   | (B) <b>Hypertension</b><br><b>years.</b>  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |   |   |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4-4-</b> <b>19 65</b> to <b>4-11</b> <b>19 65</b> , that (I) (we) last saw the deceased alive on <b>4-11</b> <b>19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. <b>XXXXX</b> |                         |   |   |  |  |
| 23A. SIGNATURE<br><b>Richard J. Kelly</b>  |                         |   |   | 23B. DATE SIGNED<br><b>4/11/65</b>                                       |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Richard J. Kelly</b>  |                         |   |   | 23D. ADDRESS<br><b>M.D.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4/14/65</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Woodlawn</b>                    |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore 7, Md.</b>   |                         |   |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Kelly</b>  |   | 25C. FUNERAL DIRECTOR<br><b>Wizke F.D. 7</b>                             |  |
| ADDRESS<br><b>4101 Edmondson Ave</b>   |                         |   |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| BIRTH NO. 10  |  | 65 3958  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3958   |  |
| M.E. CASE NO.   |  |  |  | 1. NAME OF DECEASED (Type or Print) <del>XXXXXXXXXX</del> Marie Elizabeth Heying   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE MARYLAND   |  |  |  | 2. DATE AND HOUR OF DEATH 4-10-65  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) THE JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE 5, MD  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 11-28-04 |  |  |  |
| 5. SEX F  |  |  |  | 6. RACE W.   |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY Own Home   |  | 8. DATE OF DEATH 4/26/03   |  |
| 13. FATHER'S NAME THEODORE SCHERDER   |  |  |  | 14. MOTHER'S MAIDEN NAME ELIZABETH HENKENBERN  |  | 9. AGE (In years last birthday) 61                                   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS Louis J. Heying, 414 Old Orchard Rd.           |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |  | CAUSE OF DEATH (A) Renal failure C.H.F. (B) Septicemic Tuberculosis (C) Aplastic Anemia                                    |  | INTERVAL BETWEEN ONSET AND DEATH 2 weeks                             |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION 2-28   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Cholecystitis   |  | 20A. AUTOPSY? (Yes or No) YES  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 2-27-1965 to 4-10-65 and that (I) (we) last saw the deceased alive on 4-9-65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                     |  |  |  |  |  |  |  |
| 23A. SIGNATURE Gerald A. Acker M.D.   |  |  |  | 23B. DATE SIGNED   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type) GERALD ACKER M.D.  |  |  |  | 23D. ADDRESS JOHNS HOPKINS HOSPITAL 601 N. BROADWAY BALTIMORE 5, MD  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |  | 24B. DATE 4/14/65  |  | 24C. NAME OF CEMETERY OR CREMATORY Holy Cross  |  | 24D. LOCATION Balto. Md.   |  |
| 25A. DATE REC'D BY HEALTH DEPT. APR 13 1965   |  | 25B. NAME OF REGISTRAR F. J. Witzke  |  | 25C. FUNERAL DIRECTOR F. J. Witzke   |  | 25D. ADDRESS 4101 Edmondson Ave                                      |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

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|---|--|---|--|--|--|--|--|
| 5   |  | 65 3959   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3959   |  |
| BIRTH NO.   |  |   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |
| M.E. CASE NO.   |  |   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>L. Bernardine Copenhaver</b>  |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>MRS. 4/11/65</b>   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Bm Lecons Hospital</b>  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTIMORE 23</b><br>D. STREET ADDRESS (If rural, give location) <b>428 S. Gilmore St.</b> |  |  |  |
| 5. SEX <b>F</b>   |  | 6. RACE <b>WHITE</b>  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <b>MARRIED</b>  |  | 8. DATE OF BIRTH <b>May 30, 1907</b>                                 |  |
| 9. AGE (In years last birthday) <b>57</b>   |  | 10. UNDER 1 Yr. Months: Days: Hours: Min.   |  | 11. BIRTHPLACE (State or foreign country)  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>                             |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee of</b>  |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY <b>National Casket Co. Md.</b>   |  |  |  |
| 13. FATHER'S NAME <b><del>XXXXXX</del> Schieve</b>  |  |   |  | 14. MOTHER'S MAIDEN NAME <b>HOOK</b>   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>John D. Copenhaver, 428 S. Gilmore St</b>           |  |
| 18. <b>332X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |   |  | CAUSE OF DEATH<br>(A) <b>Massive Basilar Artery Thrombosis</b><br>DUE TO<br>(B) <b>Arteriosclerosis</b><br>DUE TO<br>(C)   |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>Home</b><br><b>years</b>      |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |   |  | <b>Hypertension</b>  |  | <b>years</b>   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/10</b> 19 <b>65</b> to <b>4/11</b> 19 <b>65</b> , that (I) (we) lost saw the deceased alive on <b>4/11</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Crispin C. Linantud, Jr.</b>   |  |   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED<br><b>4-11-65</b>                                   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CRISPIN C. LINANTUD JR.</b>  |  |   |  | 23D. ADDRESS<br><b>Bm Lecons Hospital, Fayette &amp; Pulaski St.</b>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>4/14/65</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Balto. National</b>   |  | 24D. LOCATION (City, town, or county)<br><b>Balto. 29, Md</b>        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Witzke</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Witzke F.D.</b>  |  | ADDRESS<br><b>4101 Edmondson Ave</b>                                 |  |

vs 153 signed by Leroy M. Witzke licensed funeral director.

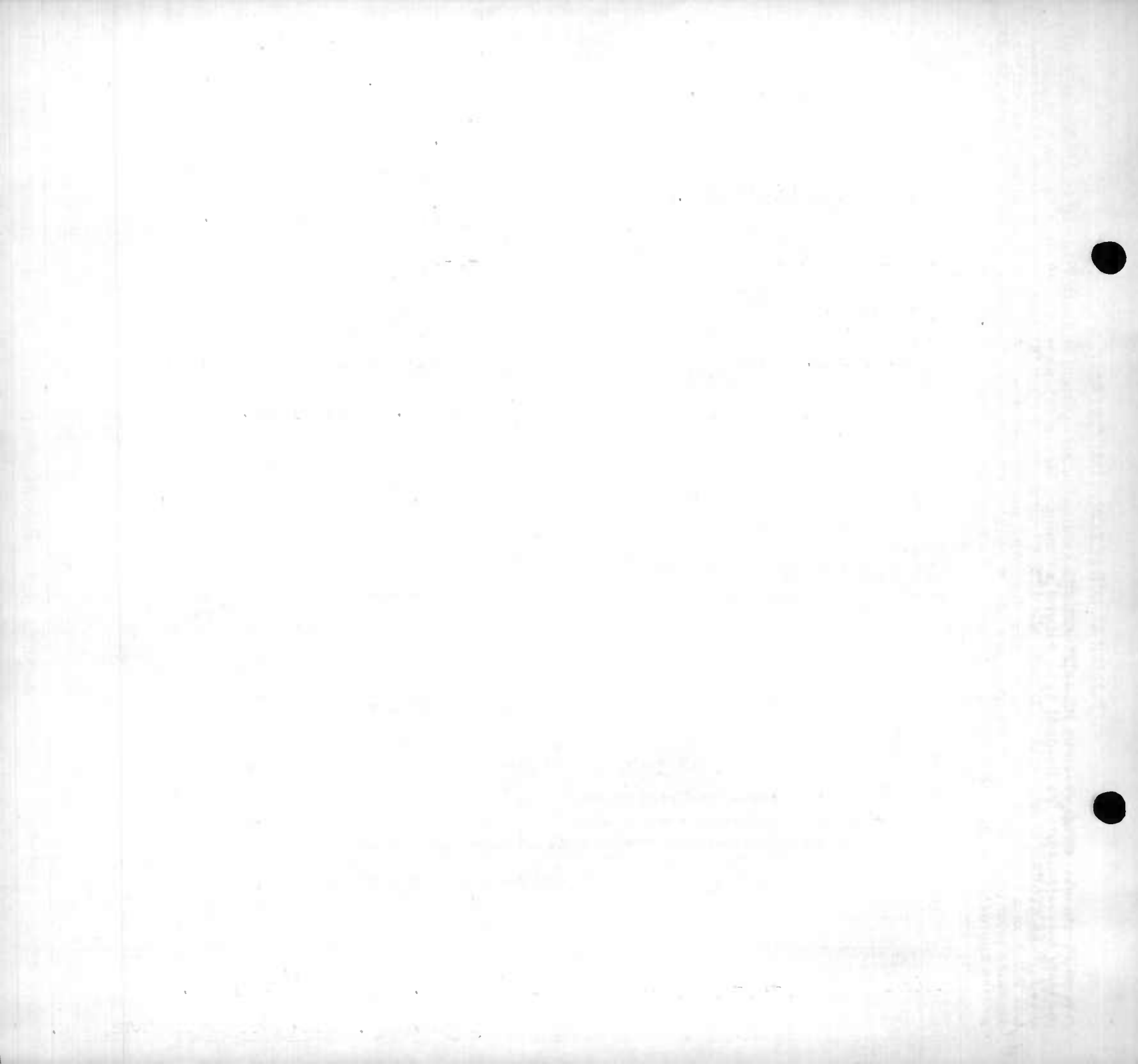
4/14/44



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

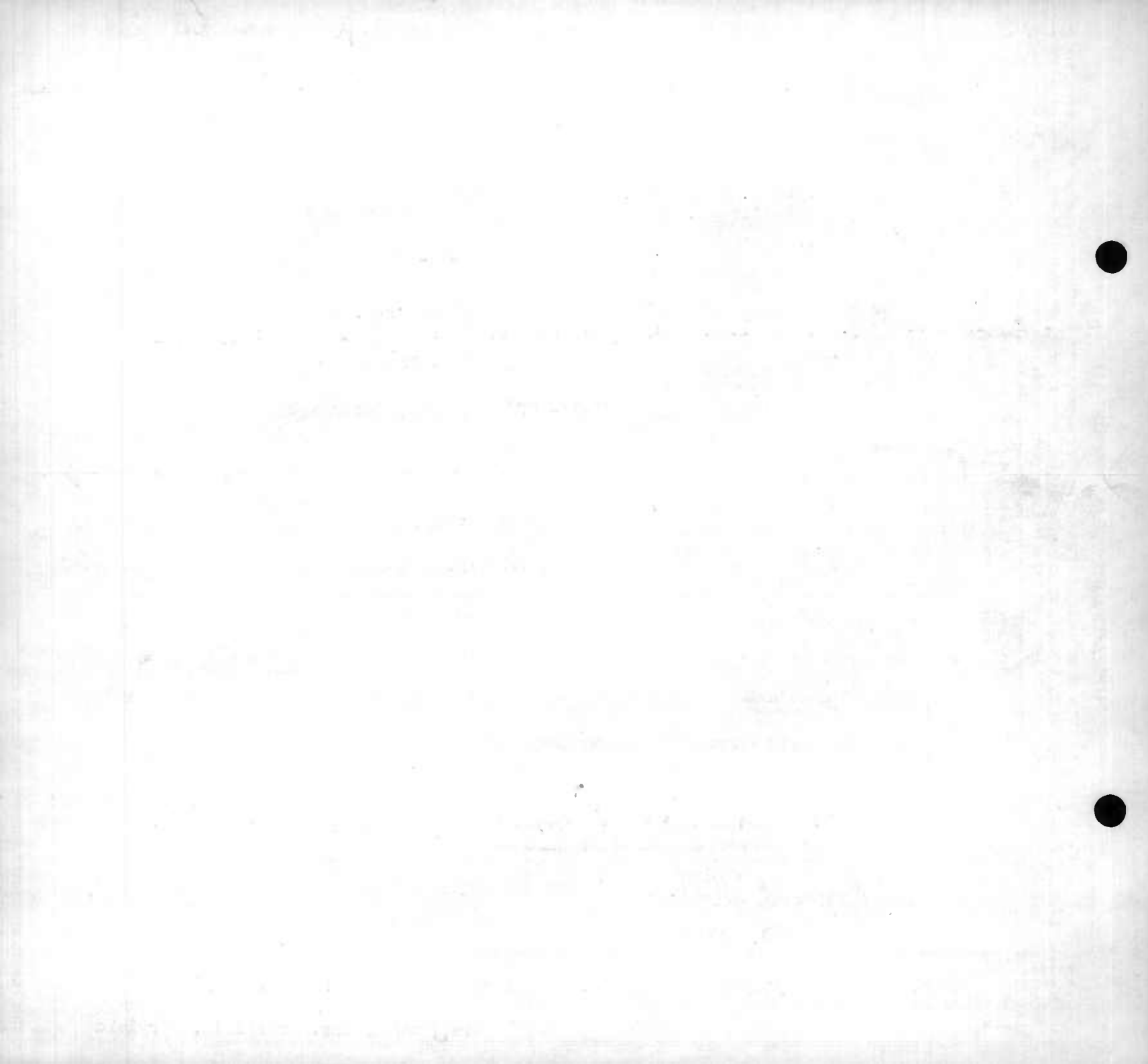
| BIRTH NO. 65 3960   |                         |  |   | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3960   |  |
|---|-------------------------|--|---|--|--|--|--|
| M.E. CASE NO.   |                         |  |   | CERTIFICATE OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Mildred M. Disney</i>   |                         |  |   | 2. DATE AND HOUR OF DEATH<br><i>April 12, 1965</i> 12 <sup>30</sup> A.M.   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br><i>5611 Belle Vista Ave.</i>  |                         |  |   | A. STATE <i>Md.</i><br>B. COUNTY <i>27-34</i>  |  |  |  |
|   |                         |  |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>Baltimore</i>  |  |  |  |
|   |                         |  |   | D. STREET ADDRESS (If rural, give location)<br><i>5611 Belle Vista Ave.</i>  |  |  |  |
| 5. SEX<br><i>female</i>   | 6. RACE<br><i>white</i> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><i>married</i>   | 8. DATE OF BIRTH<br><i>4-8-1903</i>   | 9. AGE (In years last birthday)<br><i>62</i>   | If Under 1 Yr. Months: Days:                                 | If Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>   |                         |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i> |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i> |
| 13. FATHER'S NAME<br><i>Charles B. Jones</i>  |                         |  | 14. MOTHER'S MAIDEN NAME<br><i>Anne Raborg</i>  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><i>James I. Disney, Sr.</i>                 |  | ADDRESS<br><i>same</i>                     |
| 18. <i>443X + 1 260X</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                |                         |  | CAUSE OF DEATH<br>(A) <i>Hypertensive Arteriosclerotic Cardiovascular Disease</i><br>DUE TO<br>(B) _____<br>DUE TO<br>(C) _____ |  |  | INTERVAL BETWEEN ONSET AND DEATH<br><i>3 yrs.</i>                      |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  | <i>Diabetes Mellitus.</i>   |  |  |  |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Net While <input type="checkbox"/> At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>May 1962</i> to <i>April 1965</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>March 22, 1965</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |   |  |  |  |  |
| 23A. SIGNATURE<br><i>Ernest Koff</i>  |                         |  |   | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><i>4-12-65</i>                                     |  |
| 23C. PHYSICIAN'S NAME (Type)  |                         |  |   | 23D. ADDRESS<br><i>2815 Old North Pt Rd Pketo, Md.</i>   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>burial</i>   |                         | 24B. DATE<br><i>4-14-65</i>  |   | 24C. NAME of CEMETERY or CREMATORY<br><i>Gardens of Faith Cem.</i>   |  | 24D. LOCATION (City, town, or county) (State)<br><i>Baltimore, Md.</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 13 1965</i>   |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>  |   | 25C. FUNERAL DIRECTOR<br><i>Leonard J. Buck Inc Baltimore, Md.</i>   |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

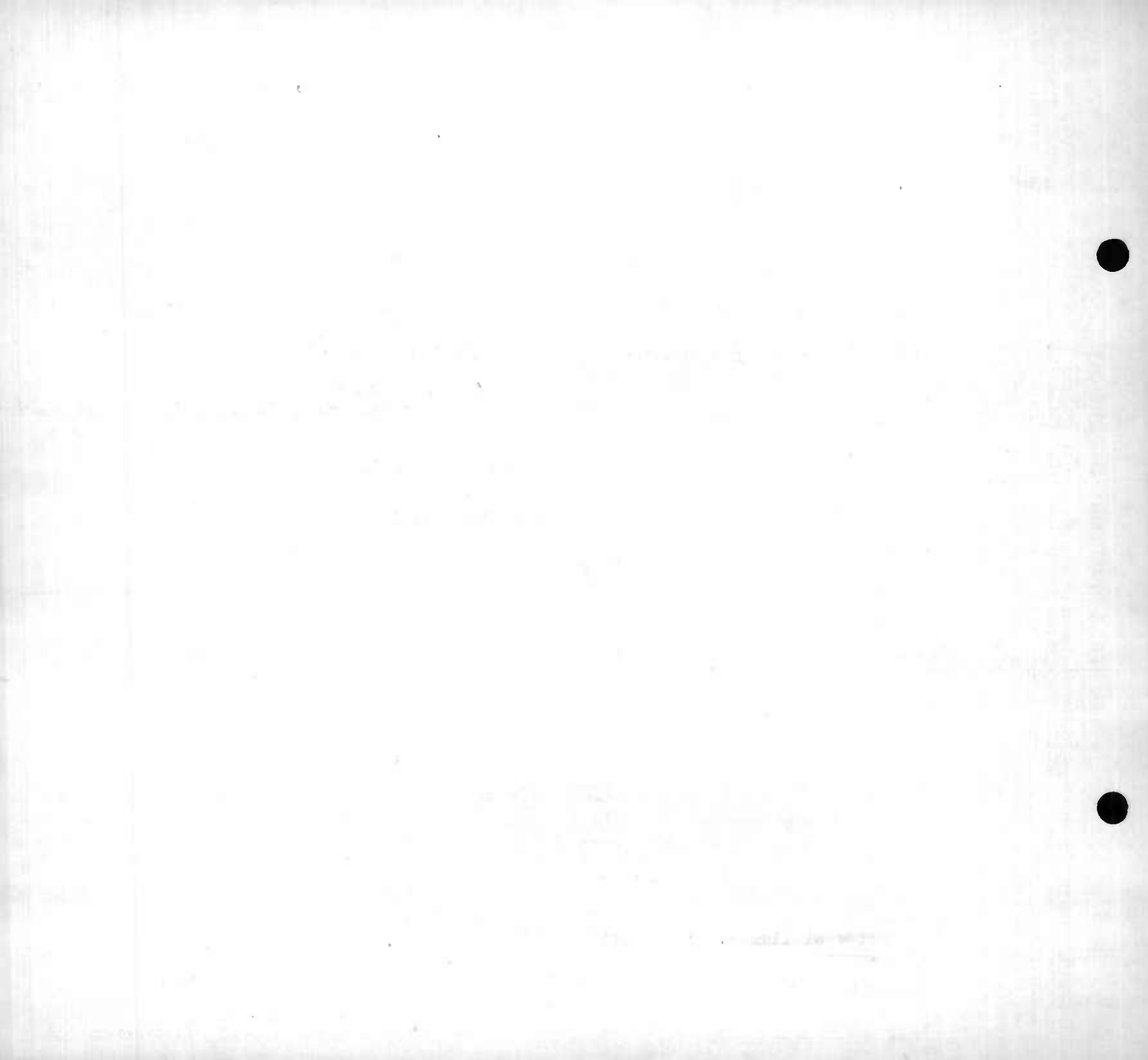
| BIRTH NO. 65 3961   |  |  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | CERTIFICATE OF DEATH   |  | Registered No. 65 3961                                  |  |
|---|--|--|--|---|--|--|--|---|--|
| M.E. CASE NO.   |  |  |  | 1. NAME OF DECEASED   |  | 2. DATE AND HOUR OF DEATH  |  |   |  |
| (Type or Print)   |  |  |  | HARBAUGH, Charles Peter   |  | April 9, 1965  |  | 3 P. M.   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |  |  |  | (If not in hospital or institution, give street address or location)                  |  | A. STATE   |  | B. COUNTY   |  |
| JENKINS MEMORIAL HOSPITAL   |  |  |  | 1000 S. Caton Ave.  |  | Maryland   |  |   |  |
| Baltimore, Md. 21229  |  |  |  |   |  | C. CITY OR TOWN  |  | (If outside city limits, write RURAL and give township) |  |
|   |  |  |  |   |  | Linthicum  |  |   |  |
| D. STREET ADDRESS (If rural, give location)   |  |  |  |   |  | #6 Oak Grove   |  |   |  |
| 5. SEX  |  | 6. RACE  |  | 7. MARRIED, NEVER MARRIED   |  | 8. DATE OF BIRTH   |  | 9. AGE (In years lost birthday)                         |  |
| M White   |  | White  |  | WIDOWED, DIVORCED (specify)   |  | 11-11-78   |  | 86  |  |
| 86  |  |  |  | Married   |  |  |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)                            |  | 12. CITIZEN OF WHAT COUNTRY?                            |  |
| Wreck Master  |  |  |  | Railroad  |  | Pittsburgh, Pa   |  | U S A   |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |   |  |
| Jacob Harbaugh  |  |  |  | Katheryn Kenner   |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |
| No  |  |  |  | 715-18-1878   |  | Medical Records Rm   |  |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  |  | CAUSE OF DEATH  |  |  |  | INTERVAL BETWEEN ONSET AND DEATH                        |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  |  |  | (A) Pneumonia   |  |  |  | 1 day   |  |
| ANTECEDENT CAUSES   |  |  |  | (B) Cachexia  |  |  |  | weeks   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | (C) chronic brain syndrome  |  |  |  | years.  |  |
| II  |  |  |  |   |  |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  |  |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
|   |  |  |  |   |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |   |  |
|   |  |  |  |   |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |   |  |
| (Month) (Day) (Year) (Hour)   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |   |  |  |  |   |  |
|   |  |  |  |   |  |  |  |   |  |
| 22. I certify that (1) (this hospital) attended the deceased from Nov 7 19 63 to April 9 19 65, that (1) (we) last saw the deceased alive on April 9 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |
| 23A. SIGNATURE  |  |  |  | 23B. DATE SIGNED  |  |  |  |   |  |
| J. Raymond Gladue   |  |  |  | 4/9/65  |  |  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)  |  |  |  | 23D. ADDRESS  |  |  |  |   |  |
| J. RAYMOND GLADUE   |  |  |  | 3350 Wilkens Ave. 21229   |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                        |  |   |  |
| Burial  |  | 4/12/65  |  | Sunnyridge Cemetery   |  | Crisfield, Maryland  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS  |  |   |  |
| APR 13 1965   |  | Robert E. Taylor   |  | Brady & Sons  |  | Crisfield, Maryland  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

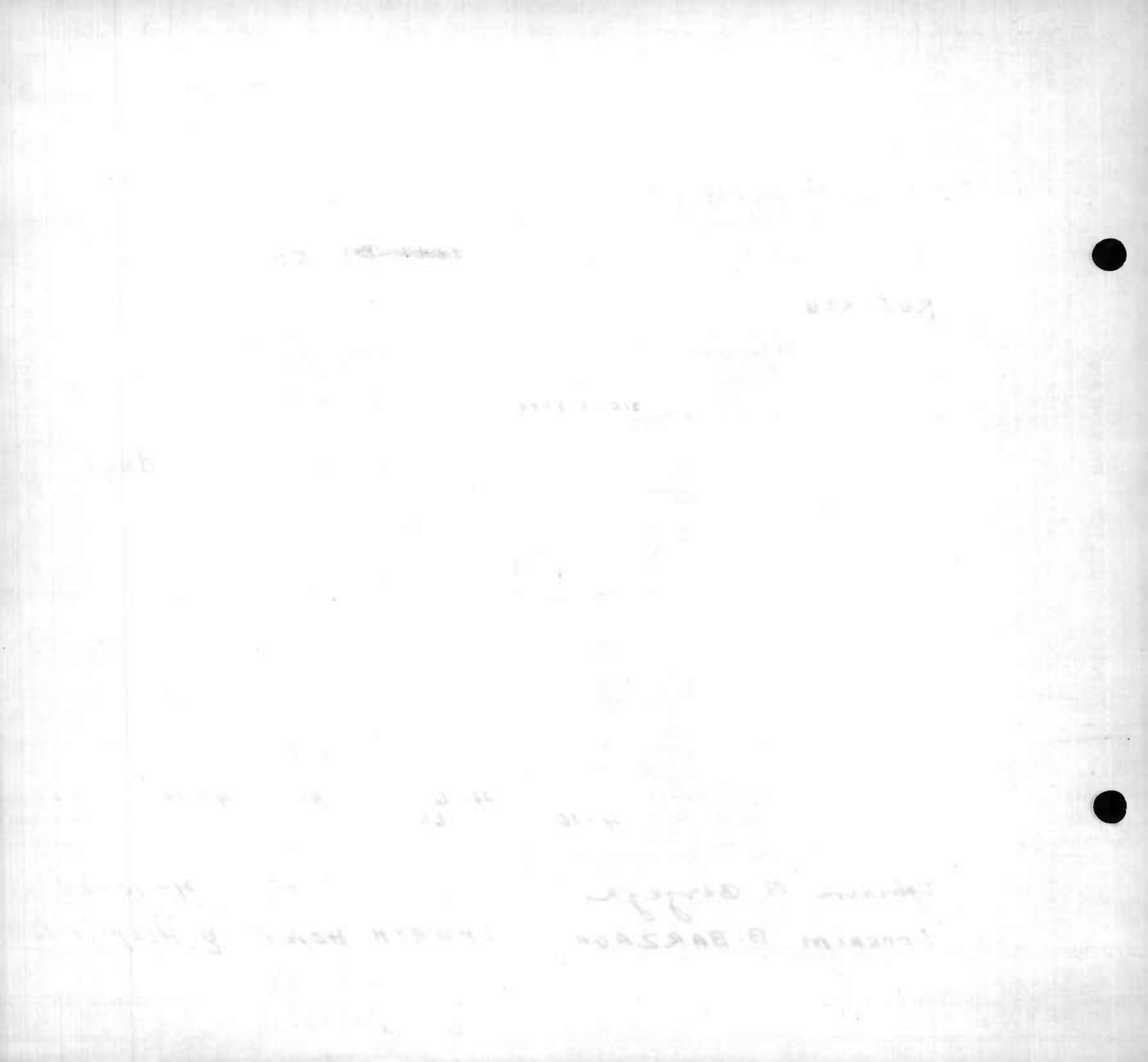
| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |                                    | 65 3962  |   | Registered No. 65 3962   |  |
|---|-------------------------|--|------------------------------------|--|---|--|--|
| BIRTH NO. 65 3962   |                         |  |                                    | CERTIFICATE OF DEATH   |   |  |  |
| M.E. CASE NO.   |                         |  |                                    | 2. DATE AND HOUR OF DEATH  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>XINTAS, MARIA</b>   |                         |  |                                    | April 10, 1965 3:05 a.m.   |   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         |  |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Joseph Hospital</b>   |                         |  |                                    | A. STATE <b>Md.</b><br>B. COUNTY <b>26-05</b>  |   |  |  |
|   |                         |  |                                    | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 24</b>                                       |   |  |  |
|   |                         |  |                                    | D. STREET ADDRESS (If rural, give location)<br><b>4907 Eastern Avenue</b>  |   |  |  |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widowed</b>                             | 8. DATE OF BIRTH<br><b>8/17/81</b> | 9. AGE (In years last birthday)<br><b>83</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>—</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Greece</b>   |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>Greece</b>                                      |  |
| 13. FATHER'S NAME<br><b>Haralambos Lambrou</b>  |                         |  |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Irene Pilleris</b>  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>—</b>  |                                    | 17. INFORMANT<br><b>Anthony Xintas</b>   |   | ADDRESS<br><b>806 Bappala Street Baltimore 24</b>                                  |  |
| 18. <b>260X-1</b> CAUSE OF DEATH  |                         |  |                                    | INTERVAL BETWEEN ONSET AND DEATH   |   |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>Purulent bronchitis</b>  |                         |  |                                    | (A) DUE TO   |   |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |  |                                    | (B) <b>Diabetes mellitus</b><br>DUE TO   |   |  |  |
|   |                         |  |                                    | (C) _____  |   |  |  |
| II  |                         |  |                                    |  |   |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |                                    |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                    | 21F. HOW DID INJURY OCCUR?   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>3/27</b> 19 <b>65</b> to <b>4/10</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/10</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                    |  |   |  |  |
| 23A. SIGNATURE<br><b>William B. VandeGrift</b>  |                         |  |                                    | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED<br><b>4/10/65</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>William B. VandeGrift</b>  |                         |  |                                    | 23D. ADDRESS<br><b>1400 N. Caroline Street, 21213</b>  |   |  |  |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>4/12/65</b>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Greek Orthodox Cemetery</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 13 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Matthews</b>  |                                    | 25C. FUNERAL DIRECTOR<br><b>Nicholas T. Matthews</b>   |   | ADDRESS<br><b>3024 Eastern Ave, Baltimore 24</b>                                   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department   |                         |   |                                    | Registered No. 65 3963   |   |
|--|-------------------------|---|------------------------------------|--|---|
| BIRTH NO.<br>65 3963   |                         | CERTIFICATE OF DEATH  |                                    | Registered No. 65 3963   |   |
| M.E. CASE NO.  |                         | 1. NAME OF DECEASED<br>(Type or Print) <i>Scheher M. Willard</i>  |                                    | 2. DATE AND HOUR OF DEATH<br><i>5:20 A.M. 4/10/65</i>                    |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)   |                                    | M.   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>CHURCH HOME HOSPITAL BALTIMORE</i>  |                         | A. STATE<br><i>Maryland</i>   |                                    | B. COUNTY<br><i>Baltimore</i>  |   |
| (If not in hospital or institution, give street address or location)   |                         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><i>BALTIMORE 21 53-00</i>                                      |                                    |  |   |
|  |                         | D. STREET ADDRESS (If rural, give location)<br><i>404 Delaware Avenue</i>   |                                    |  |   |
| 5. SEX<br><i>Male</i>  | 6. RACE<br><i>White</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><i>Married</i>  | 8. DATE OF BIRTH<br><i>8-29-09</i> | 9. AGE (In years last birthday)<br><i>55</i>                             | 10. If Under 1 Yr. Months Days Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>RETIRED</i>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>             |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>American</i>  |                         | 13. FATHER'S NAME<br><i>William Scheher</i>   |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Loretta Bankard</i>                       |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                         | 16. SOCIAL SECURITY NO.<br><i>215-03-3775</i>   |                                    | 17. INFORMANT ADDRESS<br><i>Wife (Same as above)</i>                     |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.               |                         | CAUSE OF DEATH<br>(A) DUE TO<br><i>pulmonary edema</i><br>(B) DUE TO<br><i>left Pneumonia</i><br>(C)<br><i>congestive cardiac failure</i> |                                    | INTERVAL BETWEEN ONSET AND DEATH<br><i>days</i>                          |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                         |   |                                    |  |   |
| 19A. DATE OF OPERATION<br><i>4-10-65</i>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                    |                                    | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4-6</i> 19 <i>65</i> to <i>4-10</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4-10</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |                                    |  |   |
| 23A. SIGNATURE<br><i>Ephraim B. Barzaga</i> M.D.   |                         |   |                                    | 23B. DATE SIGNED<br><i>4-10-65</i>                                       |   |
| 23C. PHYSICIAN'S NAME (Type)<br><i>EPHRAIM B. BARZAGA</i>  |                         | 23D. ADDRESS<br><i>CHURCH HOME &amp; Hospital</i>   |                                    |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 24B. DATE<br><i>4/13/65</i>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><i>Oak Lawn</i>                    |   |
| 24D. LOCATION (City, town, or county) (State)<br><i>Balto. Co. Md.</i>   |                         |   |                                    |  |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>APR 13 1965</i>  |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Taylor</i>   |                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><i>Connolly 300 Mace Ave. Balto. 21</i> |   |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |   |  |   |  |   |   |  |  |
|---|--|---|--|---|--|---|---|--|--|
| BIRTH NO. 65 3964   |  |   |  |   | CERTIFICATE OF DEATH   |   |   |  |  |
| M.E. CASE NO.   |  |   |  |   | Registered No. 65 3964   |   |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) SMITH MR TED J.  |  |   |  |   | 2. DATE AND HOUR OF DEATH<br>4-10-1965 9-25 A.M.   |   |   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |   |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |   |   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Church Home and Hospital Baltimore 31, Md.   |  |   |  |   | A. STATE B. COUNTY<br>Maryland Baltimore 20 5300   |   |   |  |  |
| C. CITY OR TOWN (If outside city limits, write RURAL and give township)   |  |   |  |   | D. STREET ADDRESS (If rural, give location)  |   |   |  |  |
| 3 Fern Place  |  |   |  |   |  |   |   |  |  |
| 5. SEX<br>Male  |  | 6. RACE<br>white  |  | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br>Married             |  | 8. DATE OF BIRTH<br>2-27-10   |   | 9. AGE (In years last birthday)<br>55 yrs. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Operating Engineer   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br>W. Va.                           |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.                                    |   | If Under 1 Yr. Months: Days: Hours: Min.   |  |
| 13. FATHER'S NAME<br>Jake Smith   |  |   |  |   | 14. MOTHER'S MAIDEN NAME<br>Alice White  |   |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>-   |  |   |  |   | 16. SOCIAL SECURITY NO.<br>236-14-5277   |   | 17. INFORMANT ADDRESS<br>Wife (Same as above) |  |  |
| 18. 4-20-1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |   |  |   | (A) myocardial fibrosis and dilation<br>(B) coronary sclerosis<br>(C)  |   |   |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |   |  |   | INTERVAL BETWEEN ONSET AND DEATH   |   |   |  |  |
| 19A. DATE OF OPERATION<br>-   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>-   |  | 20A. AUTOPSY? (Yes or No)<br>Yes  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>- |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br>-  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>-             |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>- |  |   |   |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>-  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?<br>-   |  |   |   |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3-31-1965 to 4-10-1965, that (I) (we) lost saw the deceased alive on 4-10-1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                     |  |   |  |   |  |   |   |  |  |
| 23A. SIGNATURE<br>Kishor C. Mehta   |  |   |  |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   | 23B. DATE SIGNED<br>4-10-1965                 |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>KISHOR C. MEHTA   |  |   |  |   | 23D. ADDRESS<br>Church Home and Hospital Balt. 31, Md.   |   |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Removal & Burial 4/12/65  |  | 24B. DATE<br>4/12/65  |  | 24C. NAME OF CEMETERY or CREMATORY<br>Sutton Cemetery                         |  | 24D. LOCATION (City, town, or county) (State)<br>Sutton, N. Va.           |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 15 1965  |  | 25B. NAME OF REGISTRAR<br>J. J. 6500  |  | 25C. FUNERAL DIRECTOR<br>Cordell 300 Macaw Ave. Balt. 21                      |  | ADDRESS   |   |  |  |

1953-54

1954-55

1955-56

1956-57

1957-58

1958-59

1959-60

1960-61

1961-62

1962-63

1963-64

BIRTH NO.

M.E. CASE NO.

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

1. NAME OF DECEASED  
(Type or Print)

JERRY BROWN

2. DATE AND HOUR PRONOUNCED DEAD

4/9/65 8:50 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

904 Whitelock St.

5. SEX

male

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Single

8. DATE OF BIRTH

Nov. 7, 1956

9. AGE (In years  
last birthday)

8

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Student

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Pulaski, Virginia

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

James Brown

14. MOTHER'S MAIDEN NAME

Nancy Redd

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

James Brown - 904 Whitelock St.

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

Craniocerebral injuries

(A) DUE TO

(B) DUE TO

(C) DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED20A. AUTOPSY? (Yes or No)  
no20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)

street

21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)

Whitelock St. west of Lakeview Ave.

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

4 9 65 7:10 p.m.

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

struck by car

22.

I certify that I held an Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breiteneker, M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4/10/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4-15-65

23C. NAME OF CEMETERY or CREMATORY

Mt. Auburn Cemetery

23D. LOCATION

(City, town, or county)

Baltimore, Maryland

24A. DATE REC'D BY HEALTH DEPT.

APR 14 1965

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

Charles R. Law 802 Madison Ave.

WATLEY FORD

WATLEY FORD

*W. Watley Ford*

# FUNERAL DIRECTOR: IMPORTANT

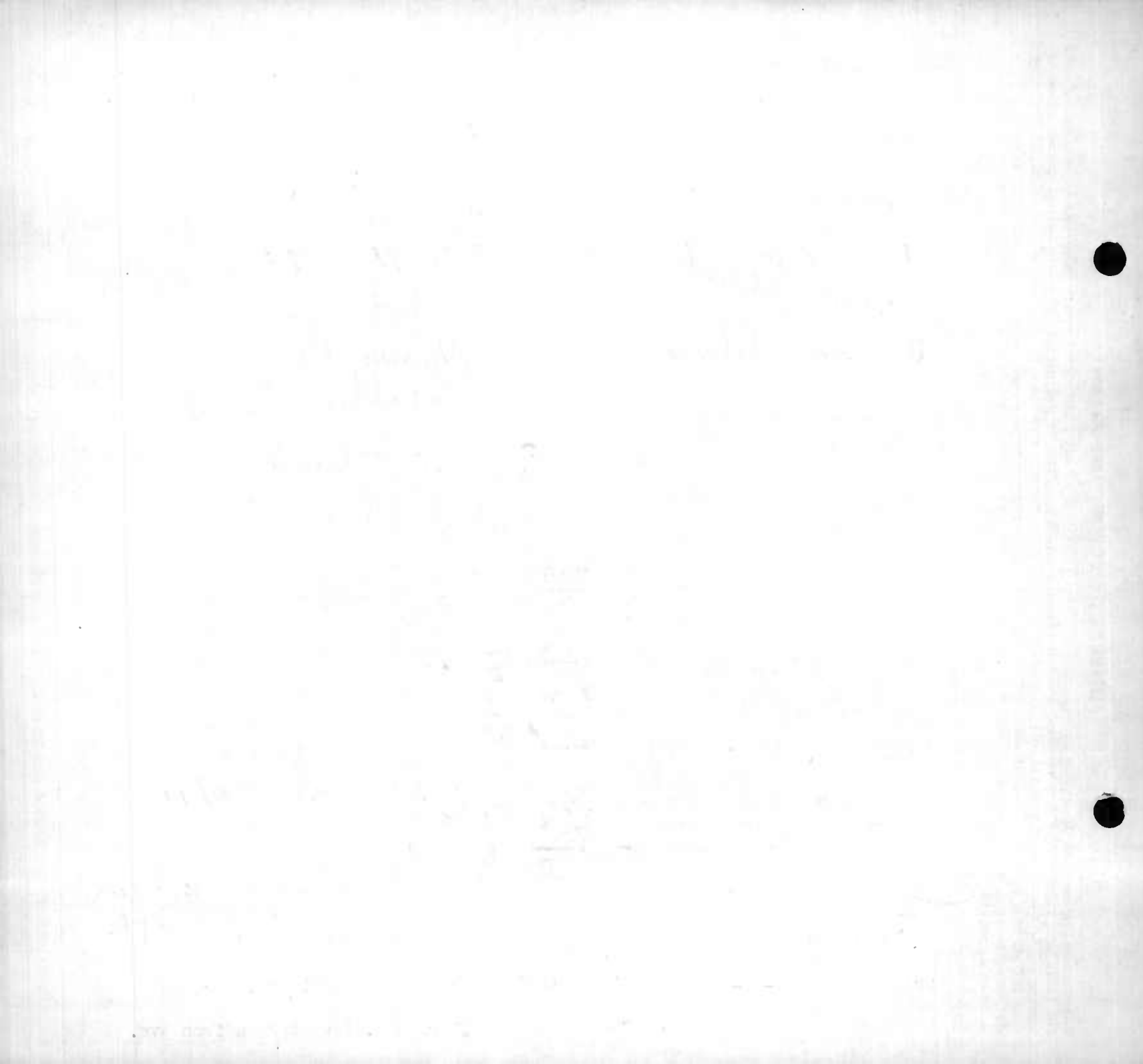
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

Registered No. **65 3966**

|   |                    |   |                                    |
|---|--------------------|---|------------------------------------|
| BIRTH NO. <b>65 3966</b>  |                    | M.E. CASE NO. <b>65 3966</b>  |                                    |
| 1. NAME OF DECEASED<br>(Type or Print) <b>FOOTE, Amanda Mae</b>   |                    | 2. DATE AND HOUR OF DEATH<br><b>April 11, 1965 1:55 P.M.</b>  |                                    |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>University Hosp - Balt.</b>   |                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md</b> B. COUNTY <b>11-84</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore</b><br>D. STREET ADDRESS (If rural, give location)<br><b>404 Cummings Ct.</b> |                                    |
| 5. SEX <b>F</b>   | 6. RACE <b>Neg</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>  | 8. DATE OF BIRTH<br><b>2/26/91</b> |
| 9. AGE (In years lost birthday) <b>74</b>   |                    | 10. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>LPN</b>   |                    | 10B. KIND OF BUSINESS OR INDUSTRY   |                                    |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>   |                    | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                                    |
| 13. FATHER'S NAME<br><b>Wilkins Johnson</b>   |                    | 14. MOTHER'S MAIDEN NAME<br><b>NANNIE PAGE</b>  |                                    |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                    | 16. SOCIAL SECURITY NO.   |                                    |
| 17. INFORMANT<br><b>Daughter.</b>   |                    | ADDRESS<br><b>2653 W North Ave<br/>Balt 16 Md.</b>  |                                    |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>332XI</b>  |                    | CAUSE OF DEATH<br>(A) DUE TO <b>Cerebral Thrombosis</b><br>(B) DUE TO <b>Cerebral Arteriosclerosis</b><br>(C) _____   |                                    |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                    | INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days.</b><br><b>?</b>  |                                    |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                    |   |                                    |
| 19A. DATE OF OPERATION<br><b>2</b>  |                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    |
| 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |                    | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                                    |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                    | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                                    |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                    | 21F. HOW DID INJURY OCCUR?  |                                    |
| 22. I certify that <del>this</del> (this hospital) attended the deceased from <b>4/9/1965</b> to <b>4/11/1965</b> , that (I) <del>we</del> last saw the deceased alive on <b>4/11/1965</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>We</del> (did) (did not) view the body after death. |                    |   |                                    |
| 23A. SIGNATURE<br><b>Donald T. Lewers MD</b>  |                    | 23B. DATE SIGNED<br><b>4/11/65</b>  |                                    |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Donald T. Lewers</b>   |                    | 23D. ADDRESS<br><b>University Hosp - Balt</b>   |                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                    | 24B. DATE<br><b>4-14-65</b>   |                                    |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Arbutus Memorial Park</b>  |                    | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |                                    |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>   |                    | 25B. NAME OF REGISTRAR<br><b>Charles R. Law</b>   |                                    |
| 25C. FUNERAL DIRECTOR<br><b>Charles R. Law</b>  |                    | ADDRESS<br><b>802 Madison Ave.</b>  |                                    |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |  |  |  |   |   |  |                                  |  |
|--|---------------------|--|--|--|---|---|--|----------------------------------|--|
| BIRTH NO. 65 3967  |                     |  |  |  | REGISTERED NO. 65 3967  |   |  |                                  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Robert White</b>   |                     |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>4-12-65 6.20 p.m.</b>   |   |  |                                  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><b>Montebello State Hospital</b>   |                     |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>94</b> |   |  |                                  |  |
| FULL NAME OF INSTITUTION (If not in hospital or institution, give street address or location)  |                     |  |  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>anne arundel 52-00</b>                                  |   |  |                                  |  |
|  |                     |  |  |  | D. STREET ADDRESS (If rural, give location)<br><b>P.O. Box 143 Severe Park</b>  |   |  |                                  |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>C</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>M</b>                                   |  | 8. DATE OF BIRTH<br><b>5-27-83</b>   | 9. AGE (In years last birthday)<br><b>81</b>  | If Under 1 Yr. Months Days  |  | If Under 24 Hrs. Hours Min.      |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired from U.S. Naval Academy Annapolis MD.</b>  |                     |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>British West Indies</b>  |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                        |  |                                  |  |
| 13. FATHER'S NAME<br><b>Robert Davis White</b>   |                     |  |  | 14. MOTHER'S MAIDEN NAME<br><b>AMANDA Taylor</b>   |   |   |  |                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     |  |  | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><b>Montebello S. Hosp.</b>                         |  |                                  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>127X1</b>   |                     |  |  | CAUSE OF DEATH<br>(A) <b>CARCINOMA of the prostate with Generalized Metastasis.</b><br>(B) DUE TO<br>(C) |   |   |  | INTERVAL BETWEEN ONSET AND DEATH |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                     |  |  |  |   |   |  |                                  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |  |                                  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |  | 21F. HOW DID INJURY OCCUR?  |   |  |                                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>(March) → 8-2 1965</b> to <b>4-12-1965</b> and that (I) (we) last saw the deceased alive on <b>4-12-1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |  |  |  |   |   |  |                                  |  |
| 23A. SIGNATURE<br><b>Orlando C. Riquers</b> M.D.   |                     |  |  |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>       |   | 23B. DATE SIGNED<br><b>4-12-65</b>                                   |                                  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Orlando C. Riquers</b> M.D.   |                     |  |  |  | 23D. ADDRESS<br><b>Montebello S. Hosp.</b>  |   |  |                                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |                     | 24B. DATE<br><b>Burial 4-16-65</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Town Neck</b>   |   | 24D. LOCATION (City, town, or county) (State)<br><b>Robinson Md</b> |  |                                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Fairbank</b>  |  | 25C. FUNERAL DIRECTOR<br><b>William Reese</b>  |   | ADDRESS<br><b>Anna Md</b>   |  |                                  |  |



9.2.2

2000-01  
2001-02  
2002-03

2003-04

2004-05  
2005-06  
2006-07

2007-08  
2008-09

2009-10

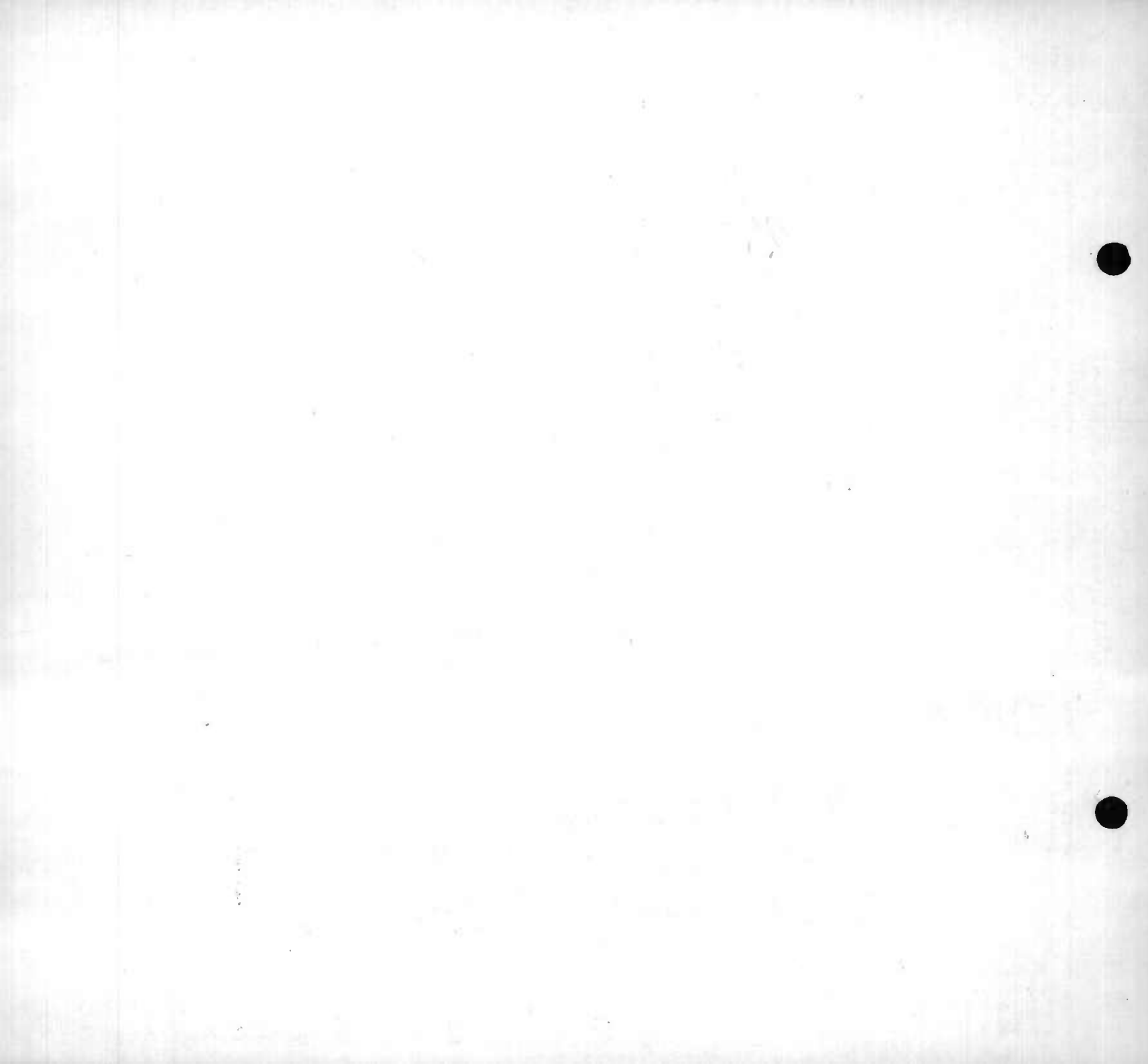
2010-11  
2011-12



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                      |  |   |  |  |  |  |   |  |
|---|----------------------|--|---|--|--|--|--|---|--|
| BIRTH NO. 65 3968   |                      |  |   |  | CERTIFICATE OF DEATH   |  |  | Registered No. 65 3968                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MATTHEWS, GEORGE</b>  |                      |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>4/12/65 12:55 P.M.</b>   |  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>FRANKLIN SQ. HOSP.</b>  |                      |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>19-02</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE</b><br>D. STREET ADDRESS (If rural, give location)<br><b>1708 W. LEYINGTON</b> |  |  |   |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>B.</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>M</b>                                     | 8. DATE OF BIRTH<br><b>6/1/03</b>                 | 9. AGE (In years last birthday)<br><b>61</b>                             | If Under 1 Yr. Months: Days: Hours: Min.   |  |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>MINISTER</b>  |                      |  | 10B. KIND OF BUSINESS OR INDUSTRY                 |  |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MD</b>    |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                  |  |
| 13. FATHER'S NAME<br><b>VEREHAH MATTHEWS</b>  |                      |  | 14. MOTHER'S MAIDEN NAME<br><b>HATTIE EDWARDS</b> |  |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                      |  | 16. SOCIAL SECURITY NO.                           |  | 17. INFORMANT ADDRESS  |  |  |   |  |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>177X I</b><br><b>CAUSE OF DEATH</b><br>(A) <b>METASTATIC CG. PROSTATE</b><br>DUE TO<br>(B) <b>no</b><br>DUE TO<br>(C) <b>no</b><br>DUE TO<br>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                      |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?   |  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/11/65</b> 19 <b>65</b> to <b>4/12</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                      |  |   |  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Dr. O. T. Brown</b> M.D.   |                      |  |   |  | 23B. DATE SIGNED   |  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>DR. O. T. BROWN</b> M.D. |  |
| 23D. ADDRESS<br><b>F.S.H.</b>   |                      |  |   |  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                      | 24B. DATE<br><b>4/17/65</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Arbiter Park</b>                |  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Baltimore Co. Md.</b> |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>   |                      | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>138 N. 9. corner St</b>  |  |  |   |  |



BIRTH NO.

65 3969

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

65 3969

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

EMMA REYNOLDS

2. DATE AND HOUR PRONOUNCED DEAD

April 10, 1965

6:20 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

1707 Harlem Avenue

5. SEX

female

6. RACE

colored

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

widow

8. DATE OF BIRTH

9. AGE (In years  
last birthday)

81

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Homemaker

10B. KIND OF BUSINESS OR INDUSTRY

At Home

11. BIRTHPLACE (State or foreign country)

Franklin N.C.

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

PINDER

14. MOTHER'S MAIDEN NAME

Sylvia

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

WM REYNOLDS 1827 WALBROOK AVE

18.

E982X1

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Multiple stab wounds of back  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

2

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERVIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIBUTING  
CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)

Home

21C. WHERE DID INJURY OCCUR?  
(If in Baltimore City, give exact location)

1707 Harlem Avenue

21D TIME  
OF INJURY  
(APPROX.)(Month) (Day) (Year) (Hour)  
4 10 65 ?

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☒

21F. HOW DID INJURY OCCUR?

Allegedly stabbed

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-10-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/15/65

23C. NAME of CEMETERY or CREMATORY

MARLBURN

23D. LOCATION

(City, town, or county)

(State)

BALTIMORE

24A. DATE REC'D BY HEALTH DEPT.

APR 14 1965

24B. NAME OF REGISTRAR

Robert E. Farley M.D.

24C. FUNERAL DIRECTOR

Monahan &amp; Sons 635 N. E. corner 5th

ADDRESS

VALLEY FORGE

RAILROAD

Point of view from the railroad

Valley Forge

BIRTH NO.

65

3970

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Registered No.

65

3970

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

RICHARD JANDORF

2. DATE AND HOUR PRONOUNCED DEAD

April 12, 1965

10:55 p. M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Sinai Hospital

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

3705 Buckingham Rd.

5. SEX

male

6. RACE

white

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

MARRIED

8. DATE OF BIRTH

8/11/1911

9. AGE (In years  
last birthday)

53

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

SALESMANAGER

10B. KIND OF BUSINESS OR INDUSTRY

REMINGTON RAND

11. BIRTHPLACE (State or foreign country)

BALTIMORE MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

USA

13. FATHER'S NAME

GUSTAVIS JANDORF

14. MOTHER'S MAIDEN NAME

RENA STRAUS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown). (If yes, give war or dates of service)

NO

16. SOCIAL  
SECURITY NO.

213-03-8176

17. INFORMANT

ADDRESS

MRS. RUBY JANDORF 3705 BUCKINGHAM RD

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)(A) Arteriosclerotic cardiovascular disease  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) DUE TO

(C) DUE TO

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING OR CONTRIB-  
UTING CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT  
WORKNOT WHILE  
AT WORK

21F. HOW DID INJURY OCCUR?

22.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Normal causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Rudiger Breitenecker

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

4-13-65

23A. BURIAL CREMATION,  
REMOVAL (Specify)

BURIAL

23B. DATE

4/14/65

23C. NAME of CEMETERY or CREMATORY

BALTIMORE HEBREW CEMETERY

23D. LOCATION

BALTIMORE

(City, town, or county)

MARYLAND

(State)

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 14 1965

SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD

SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.

W. G. R. H. I. I.



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV, 1/1/65

RECEIVED  
JAN 11 1962  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text]

1/11/62  
[illegible text]



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3972   |                  |  |                             | BALTIMORE CITY HEALTH DEPARTMENT   |                            | Registered No. 65 3972   |                             |
|---|------------------|--|-----------------------------|--|----------------------------|--|-----------------------------|
| M.E. CASE NO.   |                  |  |                             | 1. NAME OF DECEASED<br>(Type or Print) LENA SHECTER  |                            | 2. DATE AND HOUR OF DEATH<br>4/12/65 1 45 P.M.                                       |                             |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                  |  |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND B. COUNTY Baltimore       |                            | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>THE JOHNS HOPKINS HOSP   |                  |  |                             | D. STREET ADDRESS (If rural, give location)<br>MILFORD MANOR NURSING HOME  |                            |  |                             |
| 5. SEX<br>FEMALE  | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>widowed  | 8. DATE OF BIRTH<br>3/16/78 | 9. AGE (In years lost birthday)<br>87  | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>AT HOME   |                             | 11. BIRTHPLACE (State or foreign country)<br>RUSSIA  |                            | 12. CITIZEN OF WHAT COUNTRY?<br>NATURALIZED  |                             |
| 13. FATHER'S NAME<br>BARISH HOWARD STETSKY  |                  |  |                             | 14. MOTHER'S MAIDEN NAME<br>HANNAH Chai REVA?  |                            |  |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |                  | 16. SOCIAL SECURITY NO.<br>—   |                             | 17. INFORMANT<br>MR. LOUIS E. SHECTER 3526 BARTON OAKS RD  |                            |  |                             |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                  |  |                             | CAUSE OF DEATH<br>Myocardial Infarction<br>congestive failure<br>fr. @ hip   |                            | INTERVAL BETWEEN ONSET AND DEATH<br>2 hrs.<br>48 hrs<br>2 wks                        |                             |
| 19A. DATE OF OPERATION<br>3/31  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>fr. @ hip - Jewell nail  |                             | 20A. AUTOPSY? (Yes or No)<br>NO  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>nursing home             |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>MILFORD MANOR NURSING HOME, MILFORD                      |                            | 21F. HOW DID INJURY OCCUR?<br>fall<br>MILL ROAD                                      |                             |
| 21D. TIME OF INJURY (APPROX.)<br>3/29/65 12:30 PM   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> |                             |  |                            |  |                             |
| 22. I certify that (I) (this hospital) attended the deceased from 3/29 to 4/12 1965, and that (I) (we) last saw the deceased alive on 4/12 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |  |                             |  |                            |  |                             |
| 23A. SIGNATURE<br>ED Lyne MD  |                  |  |                             | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                            | 23B. DATE SIGNED<br>4/12/65  |                             |
| 23C. PHYSICIAN'S NAME (Type)<br>EVERETT D. LYNE   |                  |  |                             | 23D. ADDRESS<br>The Johns Hopkins Hosp.  |                            |  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>4/13/65   |                             | 24C. NAME OF CEMETERY or CREMATORY<br>BETH TFILOH  |                            | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE MARYLAND                  |                             |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 14 1965  |                  | 25B. NAME OF REGISTRAR<br>P. L. H. 500   |                             | 25C. FUNERAL DIRECTOR<br>SAY. REYNOLSON & BROS. 6010 REIST. RD   |                            |  |                             |



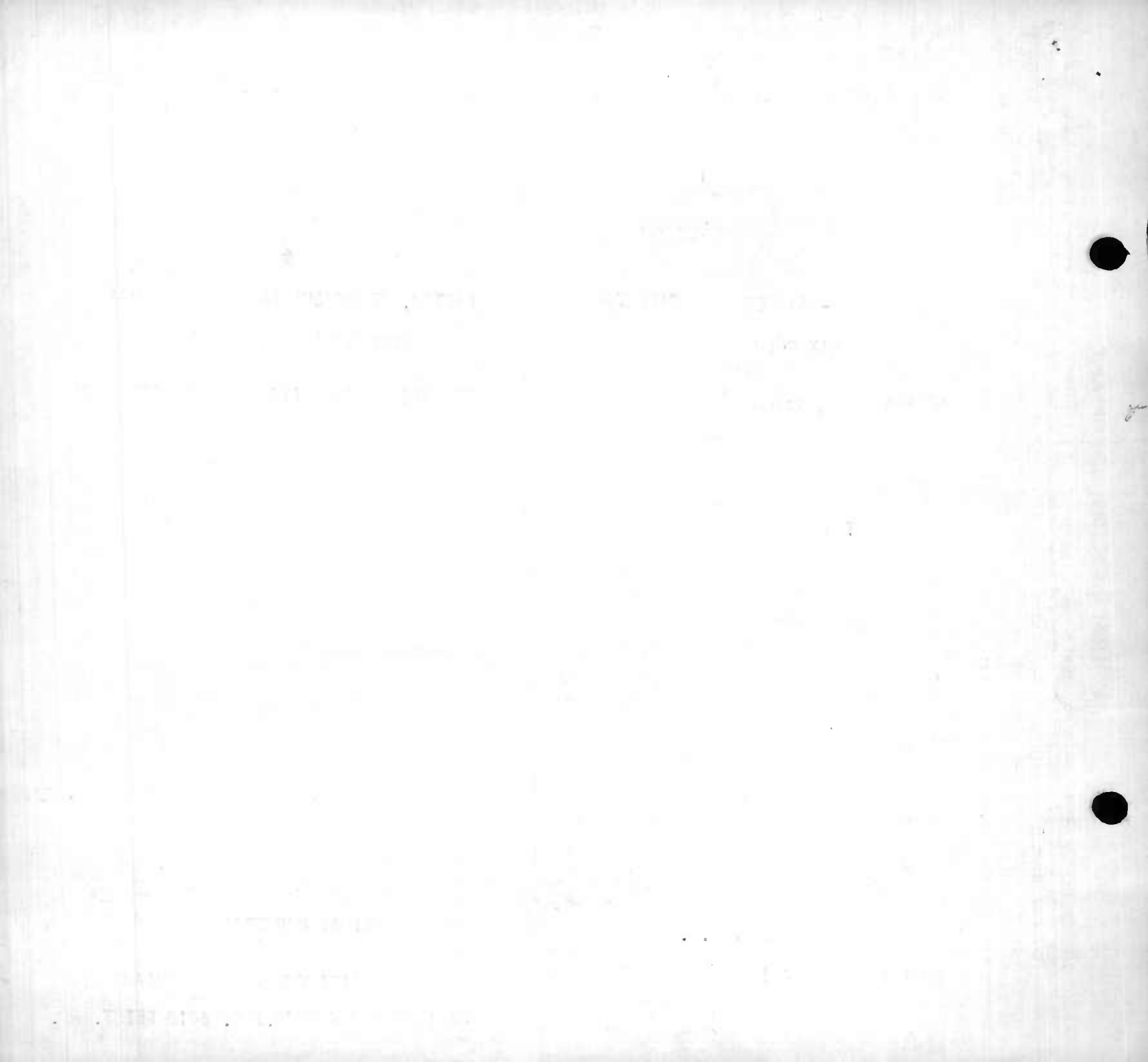
20th April

20th April 1960

**FUNERAL DIRECTOR: IMPORTANT**

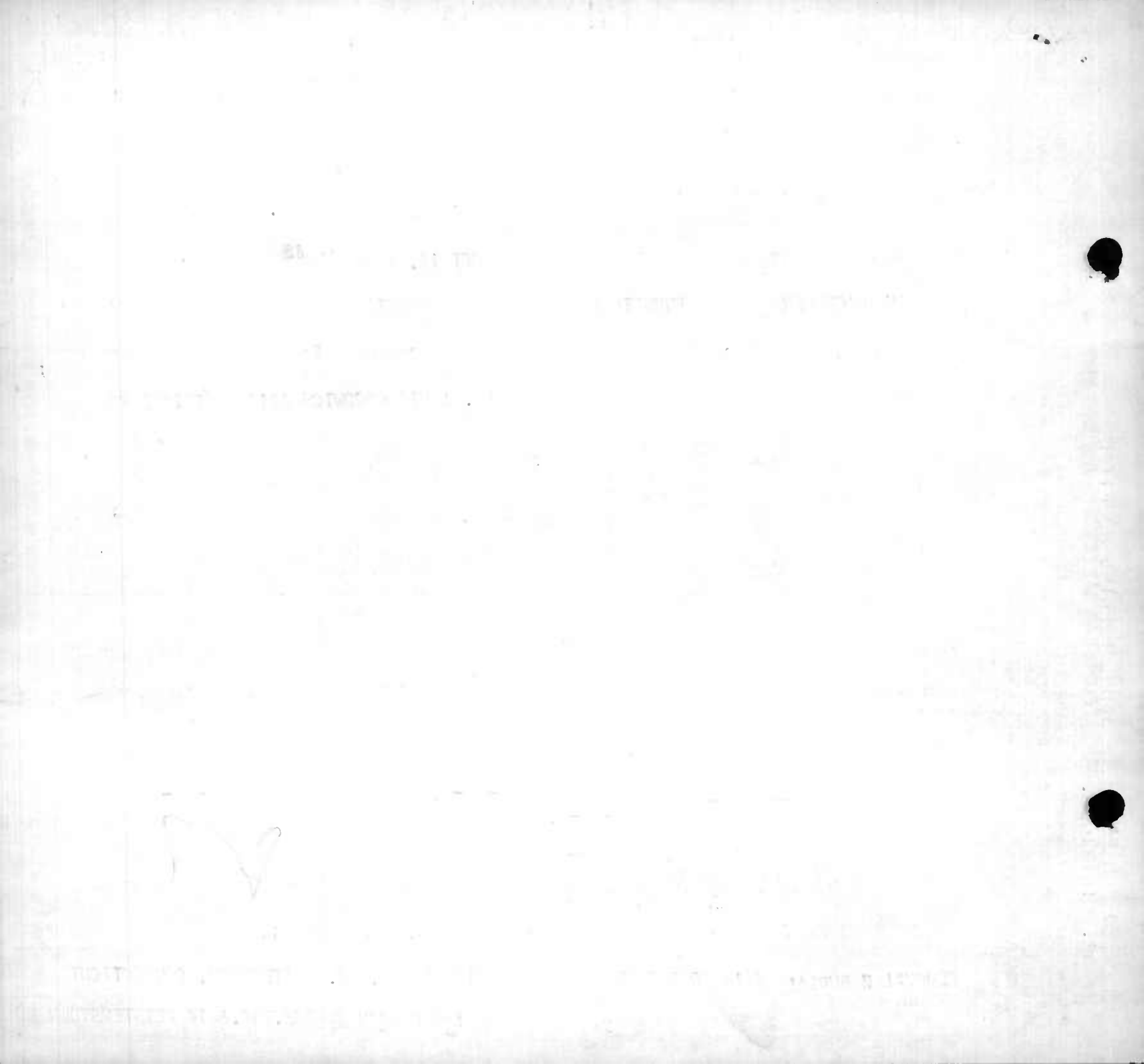
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                      |  |                                 | Certificate of Death   |  | Registered No. 65 3973  |  |
|---|----------------------|--|---------------------------------|--|--|---|--|
| BIRTH NO. 65 3973   |                      | M.E. CASE NO.  |                                 | 1. NAME OF DECEASED (Type or Print) <i>Donald Gold</i>   |  | 2. DATE AND HOUR OF DEATH <i>4/12/65 1 3<sup>35</sup> P.M.</i>          |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                      |  |                                 | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <i>Sinai Hospital</i>   |                      |  |                                 | A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i> <i>12-01</i>  |  |   |  |
|   |                      |  |                                 | C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Baltimore</i>   |  |   |  |
|   |                      |  |                                 | D. STREET ADDRESS (If rural, give location) <i>116 W. University Pkwy. Apt. 1433</i>   |  |   |  |
| 5. SEX <i>MALE</i>  | 6. RACE <i>WHITE</i> | 7. <del>MARRIED</del> NEVER MARRIED <i>MARRIED</i>                                       | 8. DATE OF BIRTH <i>3/30/11</i> |  | 9. AGE (In years last birth) <i>54</i> | 10. If Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.              |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CATERER-MANAGER</i>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY <i>CATERING</i>  |                                 | 11. BIRTHPLACE (State or foreign country) <i>EASTON, PENNSYLVANIA</i>  |  | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>                                 |  |
| 13. FATHER'S NAME <i>MAX GOLD</i>   |                      |  |                                 | 14. MOTHER'S MAIDEN NAME <i>ROSE BUGAN</i>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>XXXXXX</i>  |                      | 16. SOCIAL SECURITY NO. <i>XXXXXX</i>  |                                 | 17. INFORMANT ADDRESS <i>MISS HELEN GOLD 116 W UNIVERSITY PKWY</i>   |  |   |  |
| 18. <i>415X1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |                      |  |                                 | CAUSE OF DEATH   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES   |                      |  |                                 | (A) <i>Massive Pulmonary Embolism</i>  |  | <i>1 hour</i>   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      |  |                                 | (B) DUE TO   |  |   |  |
|   |                      |  |                                 | (C) DUE TO   |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                      |  |                                 |  |  |   |  |
| 19A. DATE OF OPERATION <i>4/12/65</i>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Pulmonary Embolism</i>               |                                 | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (Approx.)   |                      | 21E. INJURY OCCURRED   |                                 | 21F. HOW DID INJURY OCCUR?   |  |   |  |
|   |                      | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                                 |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/10</i> 19 <i>65</i> to <i>4/12</i> 19 <i>65</i> , that (I) (we) last saw the deceased alive on <i>4/12</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |  |                                 |  |  |   |  |
| 23A. SIGNATURE <i>Donald Rice</i>   |                      |  |                                 | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  | 23B. DATE SIGNED <i>4/12/65</i>   |  |
| 23C. PHYSICIAN'S NAME (Type) <i>Donald Rice, M.D.</i>   |                      |  |                                 | 23D. ADDRESS <i>SINAI HOSPITAL</i>   |  |   |  |
| 24A. BURIAL CREMATION, <i>BURIAL</i>  |                      | 24B. DATE <i>4/14/65</i>   |                                 | 24C. NAME of CEMETERY or CREMATORY <i>HAR SINAI</i>  |  | 24D. LOCATION (City, town, or county) (State) <i>BALTIMORE MARYLAND</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1965</i>  |                      | 25B. NAME OF REGISTRAR <i>R. E. F. 510</i>   |                                 | 25C. FUNERAL DIRECTOR ADDRESS <i>SOL LEVINSON &amp; BROS. INC. 6010 REIST. RD.</i>   |  |   |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

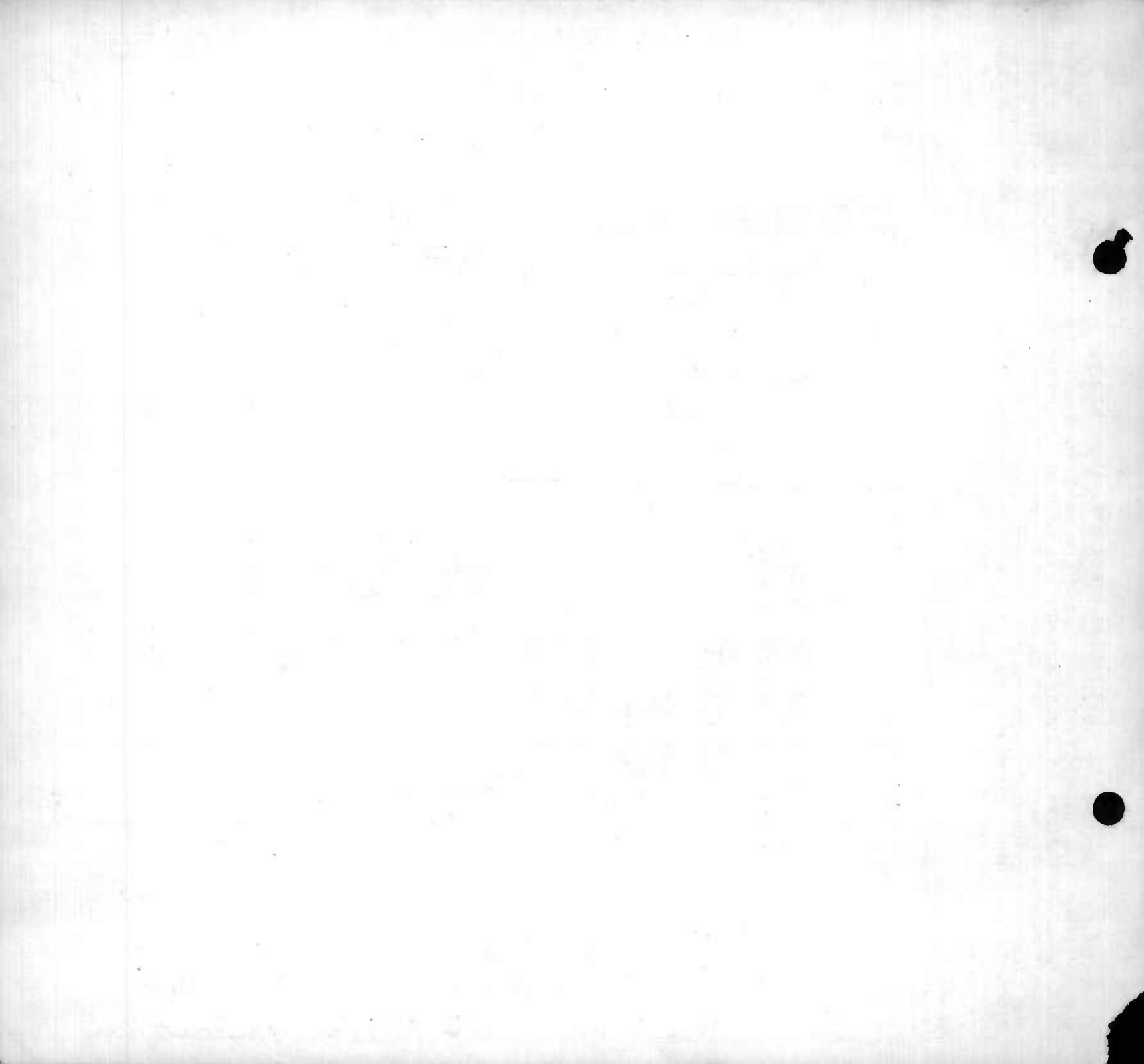
| Baltimore City Health Department  |               |   |                               | Registered No. 65 3974   |   |
|---|---------------|---|-------------------------------|--|---|
| BIRTH NO. 65 3974   |               | AARON   |                               | CERTIFICATE OF DEATH   |   |
| M.E. CASE NO.   |               | 1. NAME OF DECEASED (Type or Print) ABRAHAM GOODWICH  |                               | 2. DATE AND HOUR OF DEATH 12:55AM 4-13-65  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |                               | A. STATE MARYLAND B. COUNTY 27-16  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |               | C. CITY OR TOWN (If outside city limits, write RURAL and give township)   |                               | D. STREET ADDRESS (If rural, give location)  |   |
| JOHNS HOPKINS HOSPITAL  |               | BALTIMORE, 7  |                               | 4709 HOMER AVE.  |   |
| 5. SEX MALE   | 6. RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED  | 8. DATE OF BIRTH OCT 18, 1882 | 9. AGE (In years lost bi) 82   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MANUFACTURER  |               | 10B. KIND OF BUSINESS OR INDUSTRY FURNITURE   |                               | 11. BIRTHPLACE (State or foreign country) RUSSIA   |   |
| 12. CITIZEN OF WHAT COUNTRY? USA  |               | 13. FATHER'S NAME WILLIAM GOODWICH  |                               | 14. MOTHER'S MAIDEN NAME SARAH ?   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |               | 16. SOCIAL SECURITY NO.   |                               | 17. INFORMANT ADDRESS MR. LOUIS GOODWICH 6810 WESTRIDGE RD                                   |   |
| 18. 4-22-11 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)   |               | CAUSE OF DEATH (A) Generalized Arteriosclerotic Cardiovascular disease - (B) Acute urinary retention (C) Cardiovascular collapse. |                               | INTERVAL BETWEEN ONSET AND DEATH 36 hrs.   |   |
| 19A. DATE OF OPERATION 0  |               | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                               | 20A. AUTOPSY? (Yes or No) No   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |               | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                     |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |               | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                               | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 4-12-65 19 to 4-13-65 19 that (I) (we) last saw the deceased alive on 4-13-65 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |               |   |                               |  |   |
| 23A. SIGNATURE Bernard Kosto M.D.   |               | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>              |                               | 23B. DATE SIGNED 4/13/65   |   |
| 23C. PHYSICIAN'S NAME (Type) BERNARD KOSTO  |               | 23D. ADDRESS M.D. JOHNS HOPKINS HOSPITAL  |                               |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) REMOVAL & BURIAL   |               | 24B. DATE 4/14/65   |                               | 24C. NAME OF CEMETERY or CREMATORY INDEPENDENT BRASS CITY LODGE, INC. WATERBURY, CONNECTICUT |   |
| 25A. DATE REC'D BY HEALTH DEPT. APR 14 1966   |               | 25B. NAME OF REGISTRAR Robert E. Taylor   |                               | 25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS. INC. 6010 REISTERSTOWN RD                 |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3975  |           |  |                            | BALTIMORE CITY HEALTH DEPARTMENT  |                            | Registered No. 65 3975   |                             |
|--|-----------|--|----------------------------|---|----------------------------|--|-----------------------------|
| M.E. CASE NO.  |           |  |                            | 1. NAME OF DECEASED   |                            | 2. DATE AND HOUR OF DEATH  |                             |
| (Type or Print)  |           |  |                            | HATTIE GRAY (Harriett)  |                            | 4/8/65 3:55 P.M.   |                             |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |           |  |                            | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |                            |  |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION   |           | (If not in hospital or institution, give street address or location)                     |                            | A. STATE Maryland   |                            | B. COUNTY Baltimore City   |                             |
| 42 Swaithyke   |           |  |                            | C. CITY OR TOWN (If outside city limits, write RURAL and give township)               |                            | BALTIMORE CITY 17-02   |                             |
|  |           |  |                            | D. STREET ADDRESS (If rural, give location)   |                            | 1341 Myrtle City MYRTLE AVE  |                             |
| 5. SEX F   | 6. RACE W | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) WIDOWED                           | 8. DATE OF BIRTH 3/10/1889 | 9. AGE (In years lost birthday) 75  | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE  |           | 10B. KIND OF BUSINESS OR INDUSTRY  |                            | 11. BIRTHPLACE (State or foreign country) MARYLAND                                    |                            | 12. CITIZEN OF WHAT COUNTRY? U.S.                                    |                             |
| 13. FATHER'S NAME ?  |           |  |                            | 14. MOTHER'S MAIDEN NAME ?  |                            |  |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO  |           | 16. SOCIAL SECURITY NO. ?  |                            | 17. INFORMANT LEONARD JOHNSON   |                            | ADDRESS 2709 Mt Holly ST   |                             |
| 18. 392X1 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |           |  |                            | CAUSE OF DEATH  |                            | INTERVAL BETWEEN ONSET AND DEATH                                     |                             |
| ANTECEDENT CAUSES  |           |  |                            | (A) DUE TO Broncho pneumonia  |                            |  |                             |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |           |  |                            | (B) DUE TO Cerebral Vascular Occlusion and Congestive Heart Failure                   |                            |  |                             |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |           |  |                            | Arteriosclerotic Heart Disease  |                            |  |                             |
| 19A. DATE OF OPERATION   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            | 20A. AUTOPSY? (Yes or No)   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |
| 19A. DATE OF OPERATION   |           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                            | 20A. AUTOPSY? (Yes or No)   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                            |  |                             |
| 21D. TIME OF INJURY (APPROX.)  |           | 21E. INJURY OCCURRED   |                            | 21F. HOW DID INJURY OCCUR?  |                            |  |                             |
| 21D. TIME OF INJURY (APPROX.)  |           | 21E. INJURY OCCURRED   |                            | 21F. HOW DID INJURY OCCUR?  |                            |  |                             |
| 22. I certify that (X) (this hospital) attended the deceased from 4/8 early A.M. 1965 to 4/8 1965, that (X) (we) last saw the deceased alive on 4/8 1965 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death. |           |  |                            |   |                            |  |                             |
| 23A. SIGNATURE M. J. Kordon  |           |  |                            | 23B. DATE SIGNED 4/8/65   |                            |  |                             |
| 23C. PHYSICIAN'S NAME (Type) M. J. Kordon  |           |  |                            | 23D. ADDRESS Seward Hospital  |                            |  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |           | 24B. DATE 4/13/1965  |                            | 24C. NAME OF CEMETERY or CREMATORY Mt Auburn Cem                                      |                            | 24D. LOCATION (City, town, or county) (State) Balt Md                |                             |
| 25A. DATE REC'D BY HEALTH DEPT. APR 14 1965  |           | 25B. NAME OF REGISTRAR   |                            | 25C. FUNERAL DIRECTOR   |                            | ADDRESS  |                             |
| APR 14 1965  |           | 25B. NAME OF REGISTRAR   |                            | 25C. FUNERAL DIRECTOR   |                            | ADDRESS  |                             |





65 3976

BALTIMORE CITY HEALTH DEPARTMENT

65 3976

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH Registered No.

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

HATTIE

WILLIAMS

2. DATE AND HOUR PRONOUNCED DEAD

April 8, 1965

7:40 A

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

University Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)

Crownsville

D. STREET ADDRESS (If rural, give location)

Crownsville State Hospital

5. SEX

Female

6. RACE

Negro

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Married

8. DATE OF BIRTH

April 13, 1934

9. AGE (In years  
last birthday)

35

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working-life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Balto. md.

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Abraham Campbell

14. MOTHER'S MAIDEN NAME

Lillian Cornish

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

17. INFORMANT

Glady Lane

ADDRESS

18.

CAUSE OF DEATH

INTERVAL BETWEEN  
ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)(A) Pulmonary Embolism  
DUE TO

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.(B) Thrombophlebitis of Popliteal Vein.  
DUE TO

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR? (If in Baltimore City, give exact location)21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

WHILE AT ☐ NOT WHILE  
m. WORK AT WORK ☐

21F. HOW DID INJURY OCCUR?

22.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Charles S. Petty, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAMINER ☒  
ASSOCIATE MEDICAL EXAMINER ☐DATE SIGNED  
4/8/6523A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

23B. DATE

4/13/65

23C. NAME OF CEMETERY or CREMATORY

Mt Calvary

23D. LOCATION

(City, town, or county)

(State)

Brooklyn Md

24A. DATE REC'D BY HEALTH DEPT.

24B. NAME OF REGISTRAR

24C. FUNERAL DIRECTOR

ADDRESS

APR 14 1965

VALLEY BOULDER

PAID IN FULL

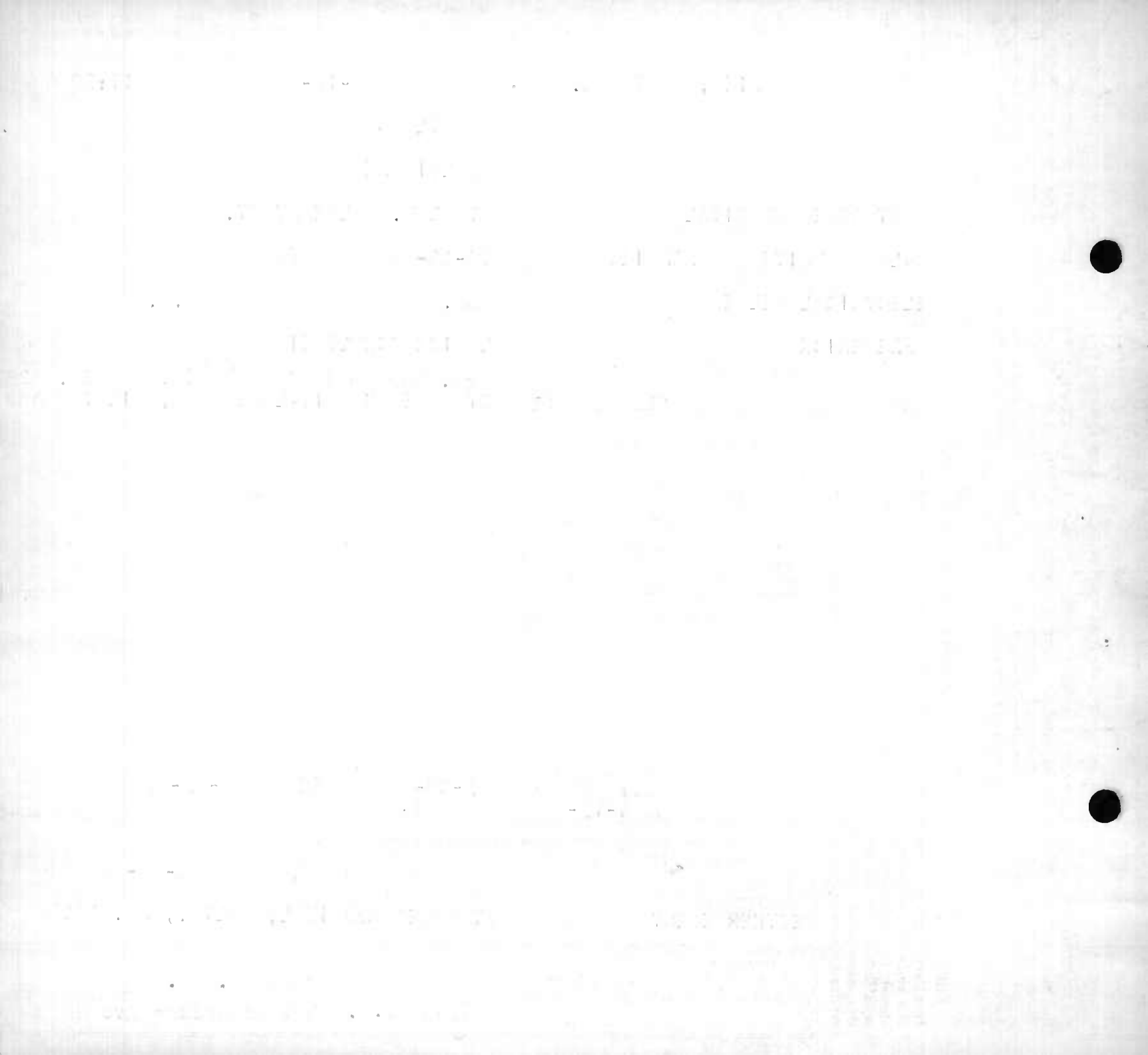
RECEIVED

WILLIAM BOULDER  
PAID IN FULL  
RECEIVED

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |                              |  |                            |  |  |
|--|------------------|---|------------------------------|--|----------------------------|--|--|
| BIRTH NO. 5  |                  | 65 3977   |                              | BALTIMORE CITY HEALTH DEPARTMENT   |                            | Registered No. 65 3977   |  |
| M.E. CASE NO.  |                  |   |                              | CERTIFICATE OF DEATH   |                            |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) RIES, JOSEPH E. SR.   |                  |   |                              | 2. DATE AND HOUR OF DEATH<br>4-13-65 11:30 A.M.  |                            |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>ST AGNES HOSPITAL   |                  |   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MARYLAND<br>B. COUNTY 20-01<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE<br>D. STREET ADDRESS (If rural, give location)<br>1852 W. MULBERRY ST. |                            |  |  |
| 5. SEX<br>MALE   | 6. RACE<br>WHITE | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>MARRIED                                       | 8. DATE OF BIRTH<br>10-22-98 | 9. AGE (In years last birthday)<br>66  | If Under 1 Yr. Months Days | If Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>ELECTRICAL WELDER   |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)<br>MD.   |                            | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.                                 |  |
| 13. FATHER'S NAME<br>FREDERICK   |                  |   |                              | 14. MOTHER'S MAIDEN NAME<br>LOUISE SCHULTHEIS (same)   |                            |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.<br>215 01 3051  |                              | 17. INFORMANT<br>Mrs. Margaret Ries CATON AVES. #29<br>ST AGNES HOSPITAL RECORDS, WILKINS AND  |                            |  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. |                  |   |                              | (A) DUE TO<br>Adenocarcinoma of the stomach with metastasis<br>(B) DUE TO<br>(C)   |                            | INTERVAL BETWEEN ONSET AND DEATH                                     |  |
| 19A. DATE OF OPERATION<br>0  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No)  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                              | 21F. HOW DID INJURY OCCUR?   |                            |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3-28-19 65 to 4-13-65 19 65 that (I) (we) last saw the deceased alive on 4-13-19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                              |  |                            |  |  |
| 23A. SIGNATURE<br>ESTHER EDERY   |                  |   |                              | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                            | 23B. DATE SIGNED<br>4-13-65  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>ESTHER EDERY   |                  |   |                              | 23D. ADDRESS<br>ST AGNES HOSPITAL, BALTO., MD. 21229   |                            |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>4/17/65  |                              | 24C. NAME OF CEMETERY or CREMATORY<br>Lakeview   |                            | 24D. LOCATION (City, town, or county) (State)<br>Carroll Co. Md.     |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 14 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Stachurski  |                              | 25C. FUNERAL DIRECTOR<br>Witzke F.D.   |                            | ADDRESS<br>4101 Edmondson Ave  |  |



|   |                             |  |   |   |  |
|---|-----------------------------|--|---|---|--|
| BIRTH NO. 65 3978   |                             | BALTIMORE CITY HEALTH DEPARTMENT   |   | 65 3978                                   |  |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                             |  |   | Registered No.                            |  |
| M.E. CASE NO.   |                             |  |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                             |  | 2. DATE AND HOUR PRONOUNCED DEAD  |   |  |
| JOSEPH HOUSTON  |                             |  | 4/10/65 12:10 a. M.   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                             |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                             |  | A. STATE B. COUNTY  |   |  |
| Franklin Square Hospital  |                             |  | Maryland  |   |  |
|   |                             |  | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |   |  |
|   |                             |  | Baltimore   |   |  |
|   |                             |  | D. STREET ADDRESS (If rural, give location)   |   |  |
|   |                             |  | 110 N. Carrollton St.   |   |  |
| 5. SEX  | 6. RACE                     | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (Specify)                                    | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)           | If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.               |
| male  | colored                     |  | April 15-   | 48  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                             | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country) |  |
| Laborer   |                             |  |   | Charlotte, N. Carolina                    |  |
| 13. FATHER'S NAME   |                             |  | 14. MOTHER'S MAIDEN NAME  |   |  |
| Unknown   |                             |  | Unknown   |   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |                             | 16. SOCIAL SECURITY NO.  | 17. INFORMANT ADDRESS   |   |  |
|   |                             |  | Mrs. Mary Miller Same   |   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) |                             |  | CAUSE OF DEATH  |   |  |
| Arteriosclerotic cardiovascular disease and diabetes mellitus   |                             |  | INTERVAL BETWEEN ONSET AND DEATH  |   |  |
| 18. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                             |  | (A) (B) (C)   |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                             |  |   |   |  |
| 19A. DATE OF OPERATION  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|   |                             |  | no  |   |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |   |  |
|   |                             |  |   |   |  |
| 21D. TIME OF INJURY (APPROX.)   | (Month) (Day) (Year) (Hour) | 21E. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK                                     | 21F. HOW DID INJURY OCCUR?  |   |  |
|   |                             |  |   |   |  |
| 22. I certify that I held an Inquiry Inspection Autopsy and that on this basis, death in my opinion resulted from: Natural causes Accident Suicide Homicide Undetermined manner                 |                             |  |   |   |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type)   |                             |  | CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER ASSOCIATE MEDICAL EXAMINER          |   |  |
| Rudiger Breiteneker, M.D.   |                             |  | DATE SIGNED 4/10/65   |   |  |
| 23A. BURIAL CREMATION, REMOVAL (Specify)  | 23B. DATE                   | 23C. NAME of CEMETERY or CREMATORY   | 23D. LOCATION (City, town, or county) (State)   |   |  |
| Burial  | 4/14/1965                   | Not known  | Baltimore Md  |   |  |
| DATE REC'D BY HEALTH DEPT.  |                             | 24B. NAME OF REGISTRAR   | 24C. FUNERAL DIRECTOR ADDRESS   |   |  |
| APR 14 1965   |                             |  | Chapman Wilson Brantley A   |   |  |

VALLEY FORGE

NOT DATED

*[Faint, illegible text, likely bleed-through from the reverse side of the page]*



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No. 65 3979

|   |                         |  |                                     |
|---|-------------------------|--|-------------------------------------|
| BIRTH NO. 65 3979   |                         | M.E. CASE NO.  |                                     |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Robert Johnson</b>  |                         | 2. DATE AND HOUR OF DEATH<br><b>April 11, 1965 12:40 P.M.</b>  |                                     |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals<br/>4940 Eastern Avenue<br/>Baltimore, Maryland, 21222</b>  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Rural</b><br>D. STREET ADDRESS (If rural, give location)<br><b>8024 Norris Road, #21222</b> |                                     |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>Negro</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Widow</b>   | 8. DATE OF BIRTH<br><b>8-4-1896</b> |
| 9. AGE (In years last birthday)<br><b>68</b>  |                         | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired)<br><b>Retired</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                                     |
| 13. FATHER'S NAME<br><b>Thomas Johnson</b>  |                         | 14. MOTHER'S MAIDEN NAME<br><b>Unknown</b>   |                                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.  |                                     |
| 17. INFORMANT<br><b>RECORDS: BCH, 4940 Eastern Ave., #21224</b>   |                         | ADDRESS  |                                     |
| 18. <b>334X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Probable Cardiac Arrest</b><br>INTERVAL BETWEEN ONSET AND DEATH<br><b>Min</b>                                      |                         | (A) DUE TO   |                                     |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         | (B) <b>Congestive Heart Failure</b><br>DUE TO <b>Years</b>   |                                     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         | (C) <b>Arterio Sclerotic Cerebral Vascular Disease</b><br>DUE TO <b>Years</b>  |                                     |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                     |
| 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                     |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                         | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                                     |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                         | 21F. HOW DID INJURY OCCUR?   |                                     |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 11 1965</b> to <b>April 11 1965</b> , that (I) (we) lost saw the deceased alive on <b>April 11 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |                                     |
| 23A. SIGNATURE<br><b>Charles C. Carpenter</b>   |                         | 23B. DATE SIGNED<br><b>April 11, 1965</b>  |                                     |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Charles C. Carpenter</b>   |                         | 23D. ADDRESS<br><b>4940 Eastern Avenue, #21224</b>   |                                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4/15/1965</b>  |                                     |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Not Calvary Cem</b>  |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Brooklyn Md</b>  |                                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>  |                                     |
| 25C. FUNERAL DIRECTOR<br><b>Charles C. Carpenter</b>  |                         | 25D. ADDRESS<br><b>4940 Eastern Avenue, #21224</b>   |                                     |

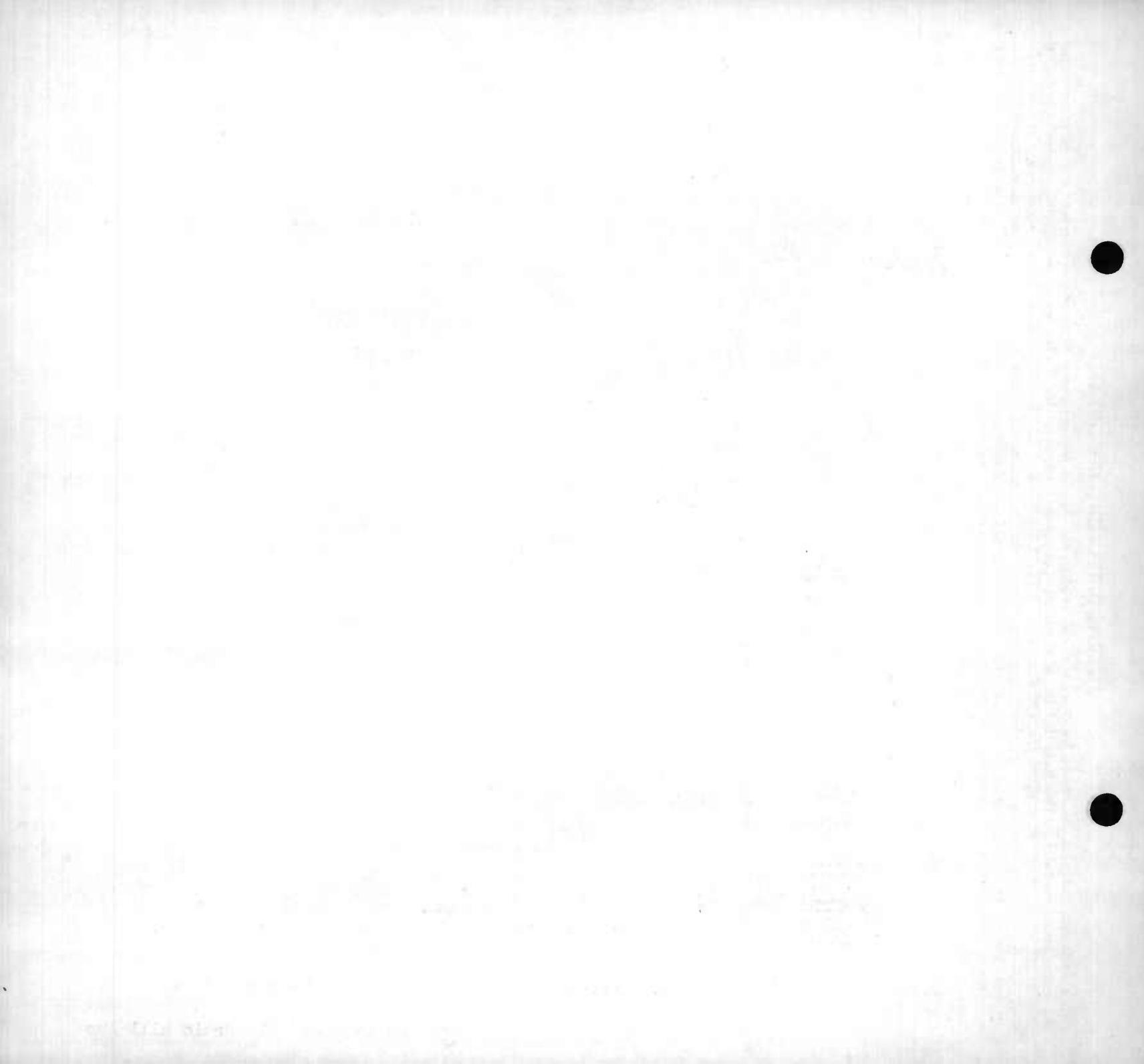
Letter from B.C.H. M.H.  
4-19-65



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

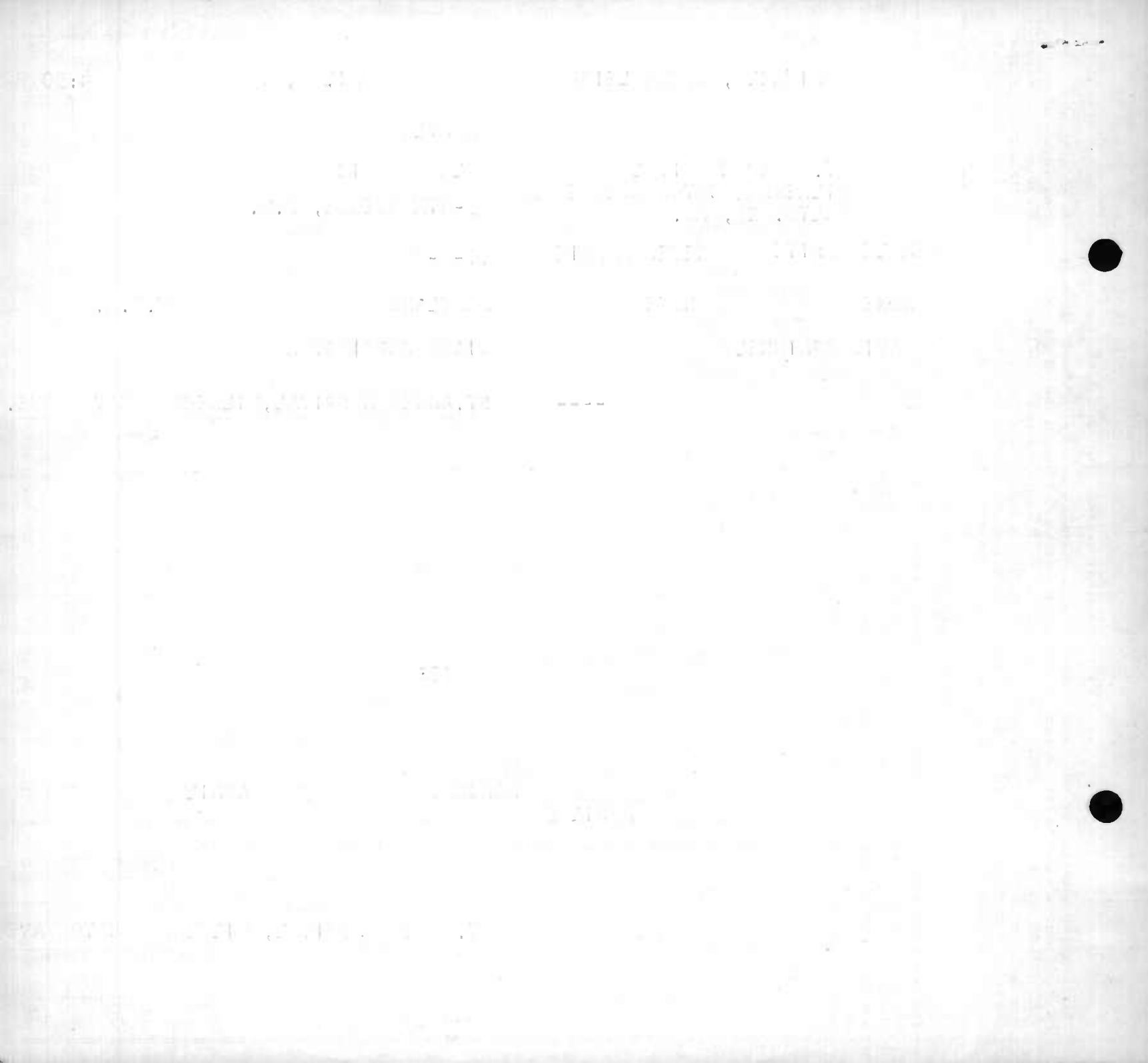
|  |         |  |                  |  |  |
|--|---------|--|------------------|--|--|
| BIRTH NO.<br>65 3980   |         | BALTIMORE CITY HEALTH DEPARTMENT   |                  | Registered No. 65 3980   |  |
| M.E. CASE NO.  |         | CERTIFICATE OF DEATH   |                  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)   |         | 2. DATE AND HOUR OF DEATH  |                  |  |  |
| William Smith  |         | April 10/65 10:30p M.  |                  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |         | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)    |                  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |         | A. STATE B. COUNTY   |                  |  |  |
| Carver Nursing Home  |         | Md 17-01   |                  |  |  |
| 407 Penna Ave  |         | C. CITY OR TOWN (If outside city limits, write RURAL and give township)                  |                  |  |  |
|  |         | D. STREET ADDRESS (If rural, give location)  |                  |  |  |
|  |         | 607 Penna Ave  |                  | PENNSYLVANIA   |  |
| 5. SEX   | 6. RACE | 7. MARRIED, (NEVER MARRIED) WIDOWED, DIVORCED (Specify)                                  | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| Male   | Negro   |  | 1-15-1882        | 83   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)                                |  |
| Laborer  |         |  |                  | Virginia   |  |
| 13. FATHER'S NAME  |         | 14. MOTHER'S MAIDEN NAME   |                  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| Bunle Jones  |         | Mattie   |                  | America  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS  |  |
|  |         |  |                  | Chant.   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |         | CAUSE OF DEATH   |                  | INTERVAL BETWEEN ONSET AND DEATH   |  |
| (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) |         | (A) DUE TO   |                  | Cerebro vascular accident  |  |
| ANTECEDENT CAUSES  |         | (B) DUE TO   |                  | arteriosclerotic cardiac   |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         | (C)  |                  | vascular disease 15 yrs.   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.                                |         |  |                  |  |  |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY (Yes or No)   |  |
| 0  |         | ✓  |                  | No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |         |  |                  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?   |  |
| (Month) (Day) (Year) (Hour)  |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from  |         | March 1 1965 to  |                  | April 10 1965  |  |
| that (I) (we) last saw the deceased alive on   |         | April 10 1965  |                  | and that in (my) (our) opinion death occurred on the date                |  |
| and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |         |  |                  |  |  |
| 23A. SIGNATURE   |         | 23B. DATE SIGNED   |                  |  |  |
| J. N. Mac MURPHY M.D.  |         | 4/11/65  |                  |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |         | 23D. ADDRESS   |                  |  |  |
| J. N. MAC MURPHY M.D.  |         | 500 E Madison St.  |                  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE  |                  | 24C. NAME OF CEMETERY or CREMATORY                                       |  |
| Burial   |         | 4/14/65  |                  | Mt Calvary Cemetery  |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR ADDRESS  |  |
| APR 14 1965  |         | Robert E. Taylor   |                  | Adolphus Halstead 918 Druid Hill Ave                                     |  |



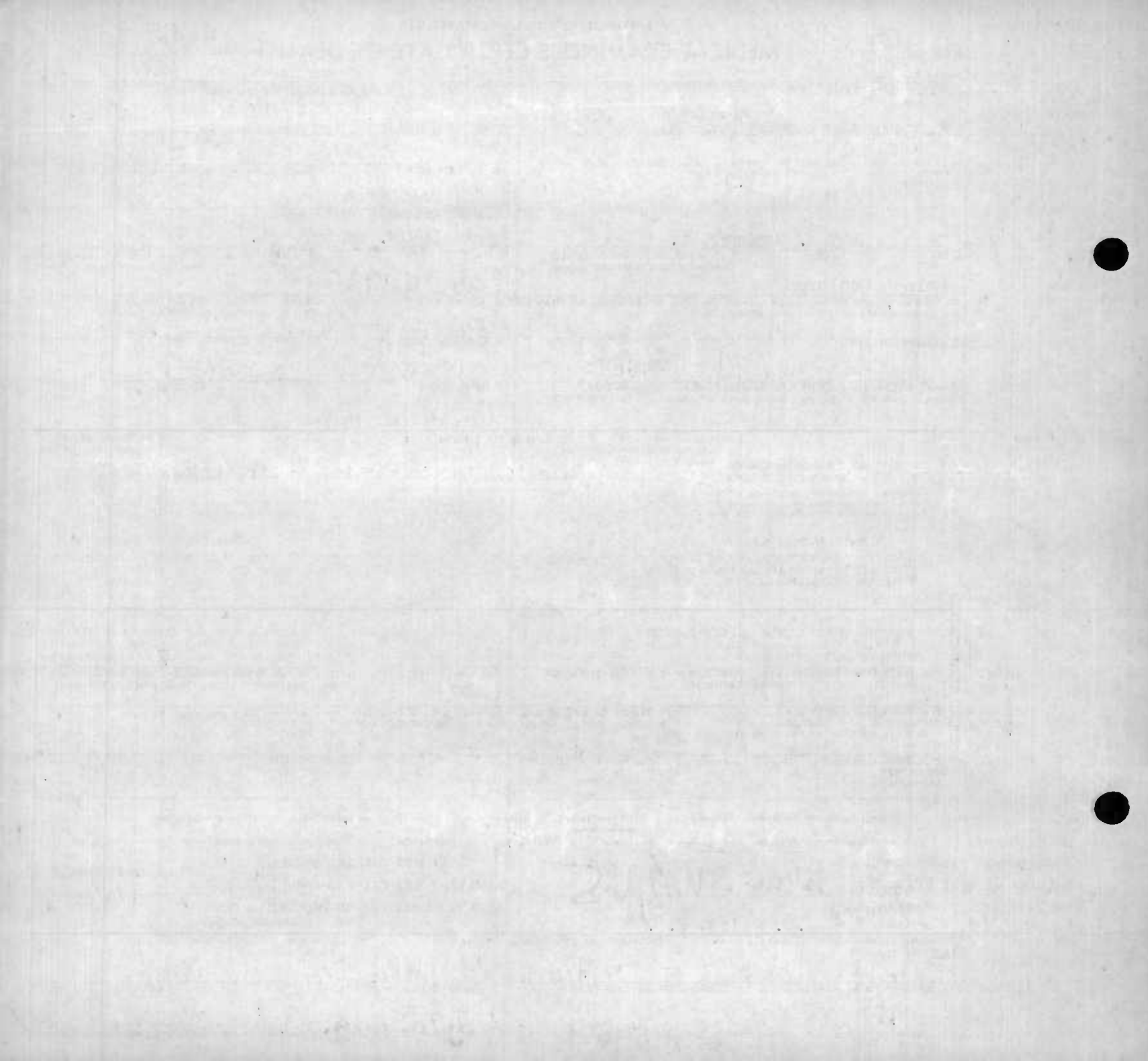
# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |  |                                    |   |   |
|---|-------------------------|--|------------------------------------|---|---|
| BIRTH NO. 65 3981   |                         | BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>  |                                    | Registered No. 65 3981  |   |
| M.E. CASE NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>SPRINKEL, DONNA LEIGH</b>  |                                    | 2. DATE AND HOUR OF DEATH<br><b>APRIL 9, 1965 4:30 P.</b>   |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>Anne Arundel</b>   |                                    | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>GLEN BURNIE 52-00</b>       |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST. AGNES HOSPITAL<br/>WILKENS &amp; CATON AVENUE<br/>BALTO. 29, MD.</b>   |                         | D. STREET ADDRESS (If rural, give location)<br><b>5-4TH AVENUE, S.W.</b>   |                                    |   |   |
| 5. SEX<br><b>FEMALE</b>   | 6. RACE<br><b>WHITE</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>NEVER MARRIED</b>   | 8. DATE OF BIRTH<br><b>11-9-64</b> | 9. AGE (In years last birthday)<br><b>5</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                         | 13. FATHER'S NAME<br><b>DAVID SPRINKEL</b>   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>DIANA SAPPINGTON</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>----</b>   |                                    | 17. INFORMANT ADDRESS<br><b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>                              |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>736.21 Biliary Atresia</b> |                         | CAUSE OF DEATH<br>(A) DUE TO <b>Biliary Atresia</b><br>(B) DUE TO <b>Congenital Absence of Gall Bladder</b><br>(C) DUE TO <b>Biliary Carcinoma</b>   |                                    | INTERVAL BETWEEN ONSET AND DEATH  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |  |                                    |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |                                    |   |   |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                         | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |                                    | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   |
| 21F. HOW DID INJURY OCCUR?  |                         | 22. I certify that (I) (this hospital) attended the deceased from <b>MARCH 16 19 65</b> to <b>APRIL 9 19 65</b> , that (I) (we) last saw the deceased alive on <b>APRIL 9 19 65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                                    |   |   |
| 23A. SIGNATURE<br><b>Grace P. Ayuyao</b>  |                         | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                                    | 23B. DATE SIGNED  |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Grace P. Ayuyao</b>  |                         | M.D. ADDRESS<br><b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE.</b>  |                                    |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>Apr. 12/65</b>   |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><b>Glen Haven Mem. Park</b>   |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Glen Burnie, Md.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>  |                                    | 25B. NAME OF REGISTRAR<br><b>Robert E. Felt</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>Raymond S. Sington</b>  |                         | ADDRESS<br><b>Glen Burnie, Md.</b>   |                                    |   |   |



| BIRTH NO. 65 3982   |         | BALTIMORE CITY HEALTH DEPARTMENT  |   | 65 3982  |  |
|---|---------|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |         |   |   | Registered No.   |  |
| M.E. CASE NO.   |         |   |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |   | 2. DATE AND HOUR PRONOUNCED DEAD  |  |  |
| FREDERICK JONES   |         |   | 4/9/65 11:50 a. M.  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |  |  |
|   |         |   | A. STATE Maryland B. COUNTY   |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |         |   | C. CITY OR TOWN (If outside corporate limits, write RURAL and give township)          |  |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |   | Baltimore   |  |  |
| 149 W. Hamburg St.  |         |   | D. STREET ADDRESS (If rural, give location)   |  |  |
|   |         |   | 119 W. Hamburg St.  |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify)                                   | 8. DATE OF BIRTH  | 9. AGE (In years last birthday)  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |
| male  | colored |   | Feb 20, 1920  | 45   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         |   | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |
|   |         |   | BALTO Md.   |  |  |
| 13. FATHER'S NAME   |         |   | 14. MOTHER'S MAIDEN NAME  |  |  |
| JOHN W. JONES   |         |   | MARTHA JAMES  |  |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown). (If yes, give war or dates of service)  |         |   | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |
|   |         |   |   |  | CARROLL JONES  |
| 18. CAUSE OF DEATH  |         |   | INTERVAL BETWEEN ONSET AND DEATH  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |   | Arteriosclerotic cardiovascular disease   |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |   | (A) DUE TO  |  |  |
| ANTECEDENT CAUSES   |         |   | (B) DUE TO  |  |  |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |         |   | (C) DUE TO  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |   |   |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)  |  |
|   |         |   |   | no   |  |
| 21A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|   |         |   |   |  |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED  |   | 21F. HOW DID INJURY OCCUR?   |  |
| (Month) (Day) (Year) (Hour)   |         | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>       |   |  |  |
|   |         |   |   |  |  |
| 22. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |         |   |   |  |  |
| ACTUAL SIGNATURE  |         | CHIEF MEDICAL EXAMINER  |   | DATE SIGNED  |  |
| EXAMINER'S NAME (Type)  |         | M.D. ASSISTANT MEDICAL EXAMINER   |   | 4/9/65   |  |
| W.U. Spitz, M.D.  |         |   |   |  |  |
| 23A. BURIAL CREMATION, REMOVAL (Specify)  |         | 23B. DATE   |   | 23C. NAME of CEMETERY or CREMATORY                                       |  |
| BURIAL  |         | 4-13-65   |   | MOUNT AUBURN   |  |
| 24A. DATE REC'D BY HEALTH DEPT.   |         | 24B. NAME OF REGISTRAR  |   | 24C. FUNERAL DIRECTOR  |  |
| APR 14 1965   |         | J. L. Broughton   |   | 123 W. MONTGOMERY ST.  |  |

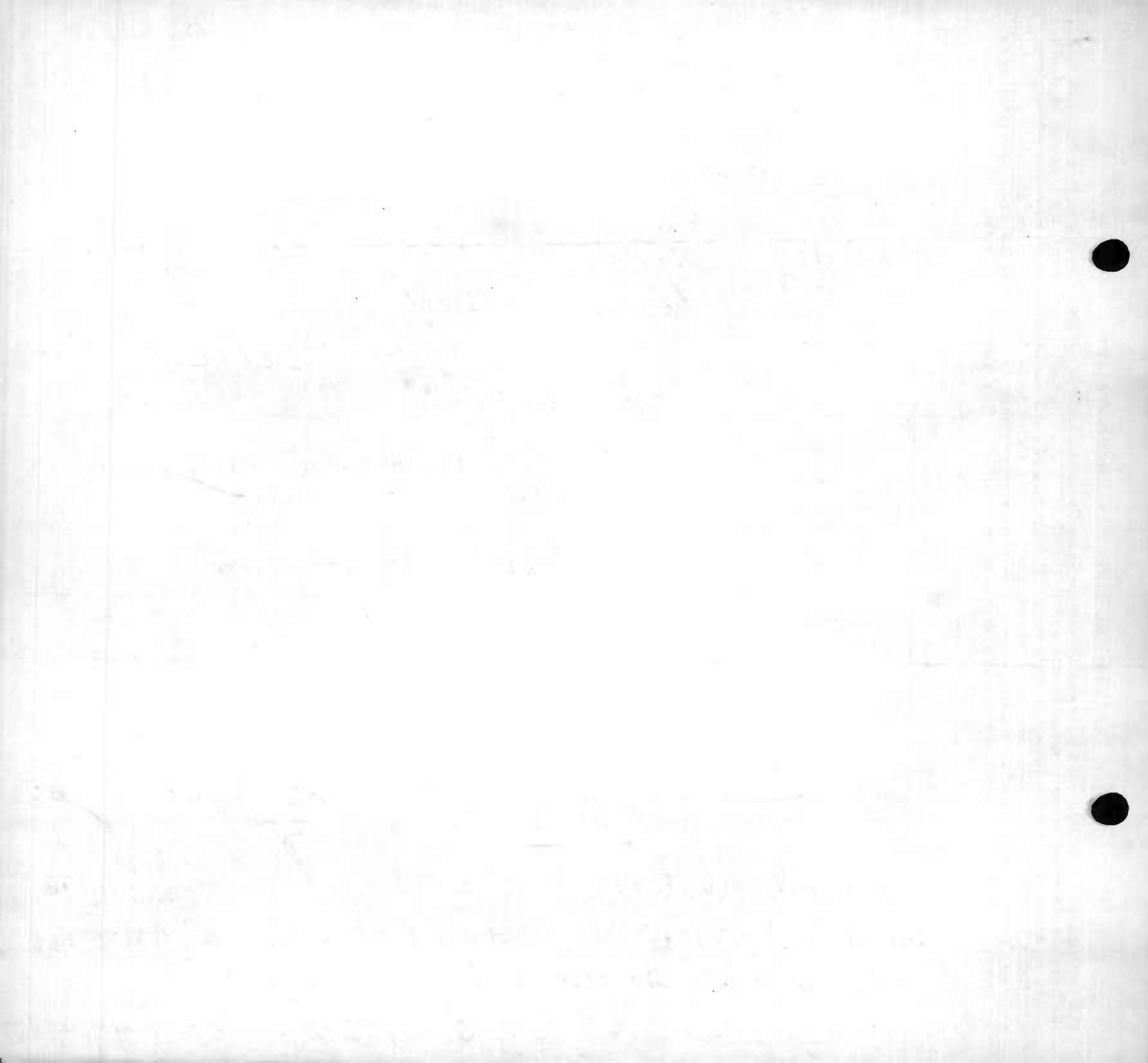


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                      |  |  |   |  |  |  |  |  | Registered No. <b>65 3983</b>  |  |
|--|----------------------|--|--|---|--|--|--|--|--|--|--|
| BIRTH NO.<br><b>65 3983</b>  |                      | M.E. CASE NO.  |  |   |  |  |  |  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>LOUIS J. RACH</b>  |                      |  |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>April 10 1965 11:45 P.M.</b>   |  |  |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                      |  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>9-06</b> |  |  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>1947 E. 31<sup>ST</sup> ST.</b>   |                      |  |  |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTO</b>  |  |  |  |  |  |
|  |                      |  |  |   |  | D. STREET ADDRESS (If rural, give location)<br><b>1947 E. 31<sup>ST</sup> ST.</b>  |  |  |  |  |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W.</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>MARRIED</b> |  | 8. DATE OF BIRTH<br><b>May 24, 83</b>   |  | 9. AGE (In years last birthday)<br><b>81</b>   |  | If Under 1 Yr. Months Days   |  | If Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                      |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>RETIRED</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto Md</b>   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| 13. FATHER'S NAME<br><b>Wm</b>   |                      |  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Marie Weber</b>   |  |  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                      |  |  | 16. SOCIAL SECURITY NO.<br><b>212-07-5438</b>   |  | 17. INFORMANT<br><b>Son</b>  |  |  |  | ADDRESS<br><b>Same</b>   |  |
| 18. <b>4 20, 01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic Heart Disease<br/>Ch Congestive failure</b>   |                      |  |  |   |  | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) <b>gen Arteriosclerosis</b>  |  |  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |  |  |
| II   |                      |  |  |   |  |  |  |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                      |  |  |   |  |  |  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |                      |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |                      |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                      |  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |  |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>July 1 1962</b> to <b>April 10 1965</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>Mar 15 1965</b> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date <b>any</b> and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death. |                      |  |  |   |  |  |  |  |  |  |  |
| 23A. SIGNATURE<br><b>Donald W. Mintzer</b>   |                      |  |  |   |  |  |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><b>April 11 1965</b>                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>DONALD W. MINTZER</b>   |                      |  |  |   |  |  |  | 23D. ADDRESS<br><b>3009 EVERGREEN AVE. BALTO MD</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                      |  |  | 24B. DATE<br><b>4/14/65</b>   |  |  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Immanuel Cem</b>  |  |  |  |
| 24D. LOCATION<br><b>Balto</b>  |                      |  |  | 24E. (City, town, or county)  |  |  |  | 24F. (State)   |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>  |                      |  |  | 25B. NAME OF REGISTRAR<br><b>RECEIVED</b>   |  |  |  | 25C. FUNERAL DIRECTOR<br><b>B. A. HEEMANN</b>  |  |  |  |
| 25D. ADDRESS<br><b>6067 N. AVE. RD</b>   |                      |  |  |   |  |  |  |  |  |  |  |



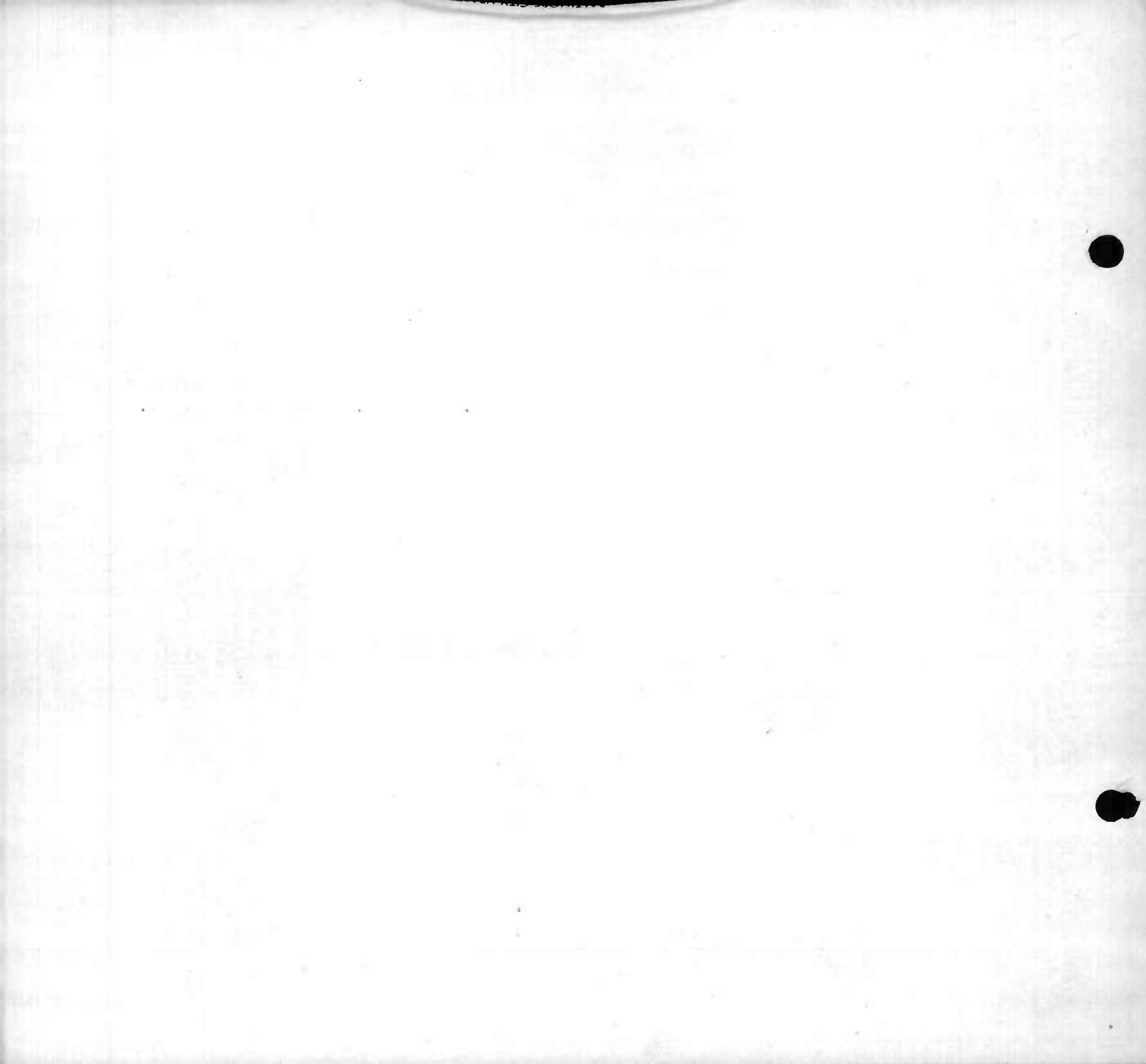




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

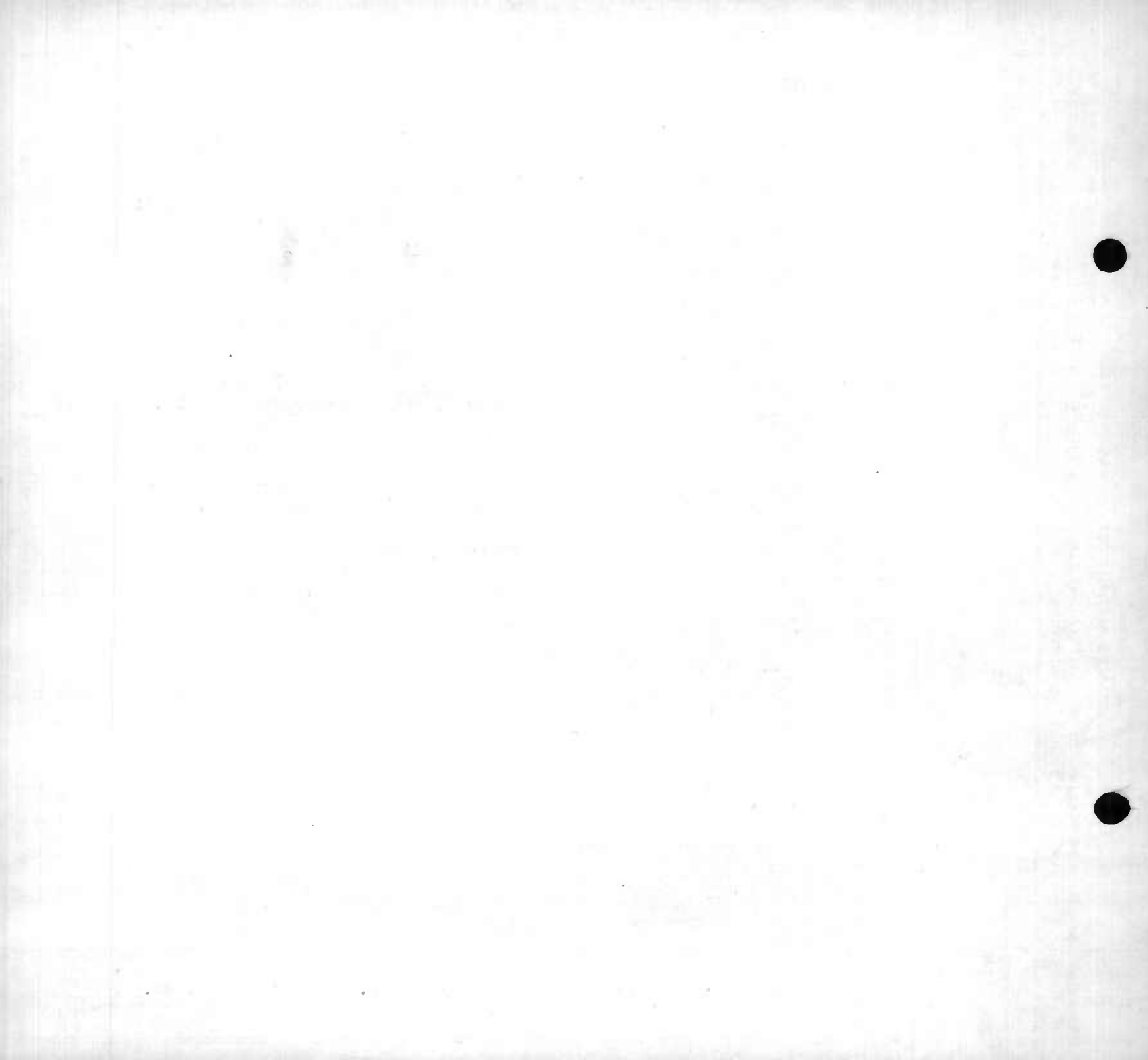
| BIRTH NO. <span style="float: right;">65 3984</span>  |         |  |                  | Baltimore City Health Department   |                            | Registered No. <span style="float: right;">65 3984</span>                            |  |
|---|---------|--|------------------|--|----------------------------|--|--|
| M.E. CASE NO.   |         |  |                  | 65 3984  |                            | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  |                  | 2. DATE AND HOUR OF DEATH  |                            |  |  |
| ALBERT LEE WHITE, II  |         |  |                  | 4/13/65  |                            | 3:07 A.M.  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |                            |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><br>THE JOHNS HOPKINS HOSPITAL   |         |  |                  | A. STATE<br>VIRGINIA   |                            |  |  |
|   |         |  |                  | B. COUNTY<br>KING  |                            |  |  |
|   |         |  |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>NORFOLK   |                            |  |  |
|   |         |  |                  | D. STREET ADDRESS (If rural, give location)<br>3658 SEWELLS POINT RD.  |                            |  |  |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)   | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days |  |  |
| MALE  | WHITE   | NEVER MARRIED  | 1/17/64          | 1 year   |                            |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)  |                            | 12. CITIZEN OF WHAT COUNTRY?   |  |
| NOT WORKING   |         |  |                  | VIRGINIA   |                            | USA  |  |
| 13. FATHER'S NAME<br>ALBERT L. WHITE  |         |  |                  | 14. MOTHER'S MAIDEN NAME<br>MAJEL JACKSON  |                            |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |         |  |                  | 16. SOCIAL SECURITY NO.  |                            | 17. INFORMANT ADDRESS<br>3658 Sewells Point Road<br>Mr. Albert L. White Norfolk, Va. |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>PNEUMONIA<br>CHRONIC LUNG DISEASE.<br>Type UNKNOWN  |         |  |                  | CAUSE OF DEATH<br>(A) DUE TO<br>(B) DUE TO<br>(C) CHRONIC LUNG DISEASE.<br>Type UNKNOWN  |                            | INTERVAL BETWEEN ONSET AND DEATH<br>6 weeks  |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |         |  |                  |  |                            |  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                 |  |
|   |         |  |                  |  |                            |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |  |  |
|   |         |  |                  |  |                            |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                  | 21F. HOW DID INJURY OCCUR?   |                            |  |  |
|   |         |  |                  |  |                            |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 4/12/65 to 4/13/65, that (I) (we) last saw the deceased alive on 4/13/65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |  |                            |  |  |
| 23A. SIGNATURE<br>H. L. Levy  |         |  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                            | 23B. DATE SIGNED<br>4/13/65  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>H. L. LEVY  |         |  |                  | 23D. ADDRESS<br>JOHNS HOPKINS HOSPITAL   |                            |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE<br>4/13/65   |                  | 24C. NAME OF CEMETERY or CREMATORY<br>Forest Lawn Cemetery   |                            | 24D. LOCATION (City, town, or county) (State)<br>Norfolk, Va.                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 14 1965  |         | 25B. NAME OF REGISTRAR<br>Robert E. Taylor   |                  | 25C. FUNERAL DIRECTOR<br>Wm. J. Pichner & Son  |                            | ADDRESS<br>Baltimore, Md. 17 North & Pa. Aves.                                       |  |



# FUNERAL DIRECTOR: IMPORTANT

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| BALTIMORE CITY HEALTH DEPARTMENT   |  |                     |  |  |  |                                    |  |   |  |   |  |   |  |  |
|--|--|---------------------|--|--|--|------------------------------------|--|---|--|---|--|---|--|--|
| BIRTH NO. 65 3985  |  |                     |  |  | CERTIFICATE OF DEATH   |                                    |  |   |  | Registered No. 65 3985  |  |   |  |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>VIRGINIA Nellie CARRUTHERS</b>  |  |                     |  |  | 2. DATE AND HOUR OF DEATH<br><b>4/13/1965 10<sup>10</sup> A.M.</b>   |                                    |  |   |  |   |  |   |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>MARYLAND GENERAL HOSPITAL</b>  |  |                     |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>ANNE ARUNDEL</b> |                                    |  |   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>GLEN BURNIE 52-00</b> |  |   |  |  |
|  |  |                     |  |  | D. STREET ADDRESS (If rural, give location)<br><b>7 FOREST ST. 21061</b>   |                                    |  |   |  |   |  |   |  |  |
| 5. SEX<br><b>F</b>   |  | 6. RACE<br><b>W</b> |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>Never Married</b> |  | 8. DATE OF BIRTH<br><b>8/12/12</b> |  | 9. AGE (In years lost birth)<br><b>52</b> |  | 11. BIRTHPLACE (State or foreign country)<br><b>VA.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>INSPECTOR</b>  |  |                     |  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>J.H. WHITEHURST CO.</b>  |                                    |  |   |  |   |  |   |  |  |
| 13. FATHER'S NAME<br><b>ROBERT CARRUTHERS</b>  |  |                     |  |  | 14. MOTHER'S MAIDEN NAME<br><b>ELIZABETH COBB</b>  |                                    |  |   |  |   |  |   |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |  |                     |  |  | 16. SOCIAL SECURITY NO.  |                                    |  |   |  | 17. INFORMANT ADDRESS<br><b>7 Forst Street<br/>Miss Dorothy Hoxter Glen Burnie, Maryland</b>        |  |   |  |  |
| 18. I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>II. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.        |  |                     |  |  | CAUSE OF DEATH<br><b>PERITONITIS GENERALIZED<br/>PERFORATION OF JEJUNUM<br/>CARCINOMA of PANCREAS</b>                                      |                                    |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |  |
| MEDICAL CERTIFICATION  |  |                     |  |  |  |                                    |  |   |  |   |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |  |                     |  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                    |  |   |  | 20A. AUTOPSY? (Yes or No)<br><b>Yes</b>   |  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  |                     |  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                    |  |   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                            |  |   |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  |                     |  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                     |                                    |  |   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>4/7</b> 19 <b>65</b> to <b>4/13</b> 19 <b>65</b> , that (1) (we) last saw the deceased alive on <b>4/13</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |                     |  |  |  |                                    |  |   |  |   |  |   |  |  |
| 23A. SIGNATURE<br><b>Edward A. Person</b> M.D.   |  |                     |  |  | 23B. DATE SIGNED<br><b>4/13/65</b>   |                                    |  |   |  |   |  |   |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  |                     |  |  | 23D. ADDRESS<br>M.D.   |                                    |  |   |  |   |  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  |                     |  |  | 24B. DATE<br><b>4/17/1965</b>  |                                    |  |   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Meadowridge Memorial Park Cent.</b>                        |  |   |  |  |
|  |  |                     |  |  |  |                                    |  |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Howard County, Md.</b>                          |  |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>  |  |                     |  |  | 25B. NAME OF REGISTRAR<br><b>W. J. Dickerson</b>   |                                    |  |   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Balto. Md. 21217 North La. aves.</b>                            |  |   |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                  |  |                                 | Registered No. 65 3986   |  |
|--|------------------|--|---------------------------------|--|--|
| BIRTH NO. 65 3986  |                  |  |                                 | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Marvin E. Skipper</i>  |                  | 2. DATE AND HOUR OF DEATH<br><i>4/12/65 9:40 P.M.</i>  |                                 |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><i>Mary Hospital Balto</i>   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <i>Md</i> B. COUNTY <i>Baltimore</i><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>4618 York Rd, Baltimore</i><br>D. STREET ADDRESS (If rural, give location) <i>27-11</i> |                                 |  |  |
| 5. SEX <i>M</i>  | 6. RACE <i>W</i> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) <i>married</i>  | 8. DATE OF BIRTH <i>5/30/15</i> | 9. AGE (In years last birthday) <i>45</i>                                | If Under 1 Yr. Months: Days: Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>C.P.A. (disabled)</i>   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>               |  |
| 13. FATHER'S NAME <i>Joseph Skipper</i>  |                  | 14. MOTHER'S MAIDEN NAME <i>Shady Lowry</i>  |                                 | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>                                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>YES WW II</i>  |                  | 16. SOCIAL SECURITY NO. <i>214-03-6042</i>   |                                 | 17. INFORMANT <i>CATHERINE F. SKIPPER (SAME)</i>                         |  |
| 18. <i>592X I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |                  | CAUSE OF DEATH<br>(A) <i>pericarditis MI</i><br>(B) <i>electrolyte imbalance</i><br>(C) <i>chronic glomerulo</i>   |                                 |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                  | II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Chronic Brain Syndrome</i>   |                                 |  |  |
| 19A. DATE OF OPERATION <i>none</i>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20A. AUTOPSY? (Yes or No) <i>yes</i>                                     |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <i>none</i>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)  |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                 | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>4/4</i> 19 <i>65</i> to <i>4/12</i> 19 <i>65</i> , that (I) (we) lost saw the deceased alive on <i>4/12</i> 19 <i>65</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |  |                                 |  |  |
| 23A. SIGNATURE <i>W.E. Schwartz</i>  |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                                 | 23B. DATE SIGNED <i>4/13/65</i>  |  |
| 23C. PHYSICIAN'S NAME (Type) <i>W.E. SCHWARTZ</i>  |                  | 23D. ADDRESS <i>MERCY HOSP. BALTO. Md.</i>   |                                 |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>   |                  | 24B. DATE <i>4/16/1965</i>   |                                 | 24C. NAME OF CEMETERY or CREMATORY <i>Baltimore National Cem.</i>        |  |
|  |                  |  |                                 | 24D. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>      |  |
| 25A. DATE REC'D BY HEALTH DEPT. <i>APR 14 1965</i>   |                  | 25B. NAME OF REGISTRAR <i>H.W. Jenkins &amp; Sons Co.</i>  |                                 | 25C. FUNERAL DIRECTOR ADDRESS <i>4905 York Rd. Baltimore 12, Md.</i>     |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |  |   | Registered No. <b>65 3987</b>  |   |
|---|-------------------------|--|---|--|---|
| BIRTH NO. <b>65 3987</b>  |                         | <b>CERTIFICATE OF DEATH</b>  |   |  |   |
| M.E. CASE NO.   |                         | 1. NAME OF DECEASED<br>(Type or Print) <b>Ernst, Annie R.</b>  |   | 2. DATE AND HOUR OF DEATH<br><b>April 13, 1965 11:40 P.M.</b>            |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>St. Joseph Hospital</b>   |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>27-10</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>Baltimore 21212</b><br>D. STREET ADDRESS (If rural, give location)<br><b>603 Springfield Ave.</b> |   |  |   |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>Widowed</b>   | 8. DATE OF BIRTH<br><b>March 28, 1883</b> | 9. AGE (In years last birthday)<br><b>82</b>                             | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Homemaker</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Own Home</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                         | 13. FATHER'S NAME<br><b>Charles E. Soper</b>   |   | 14. MOTHER'S MAIDEN NAME<br><b>Alberta Jeffries</b>                      |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>216-05-7416D</b>   |   | 17. INFORMANT<br><b>Albert Ernst, 3114 Northwind Rd.</b>                 |   |
| 18. <b>420.11</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Widespread myocardial ischemia and diaphragmatic antero-lateral myocardial infarction.</b>                          |                         | CAUSE OF DEATH   |   | INTERVAL BETWEEN ONSET AND DEATH   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.  |                         | (A) <b>Widespread myocardial ischemia and diaphragmatic antero-lateral myocardial infarction.</b>  |   |  |   |
| (B) DUE TO  |                         |  |   |  |   |
| (C)   |                         |  |   |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                         |  |   |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1965</b> to <b>April 13, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 13, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |   |  |   |
| 23A. SIGNATURE<br><br>Anastacio Subong, Jr.   |                         |  |   | 23B. DATE SIGNED<br><b>April 13, 1965</b>                                |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Anastacio Subong, Jr.</b>  |                         | 23D. ADDRESS<br><b>1400 N. Caroline St., Baltimore, Md. 21213</b>  |   |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>4/16/1965</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Lorraine Park Cem.</b>          |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Balto. Co., Md.</b>   |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>  |   |  |   |
| 25B. NAME OF REGISTRAR<br><b>R. E. St. John</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>H. W. Jenkins &amp; Sons Co. 4905 York Road Balto. 12, Md.</b>   |   |  |   |

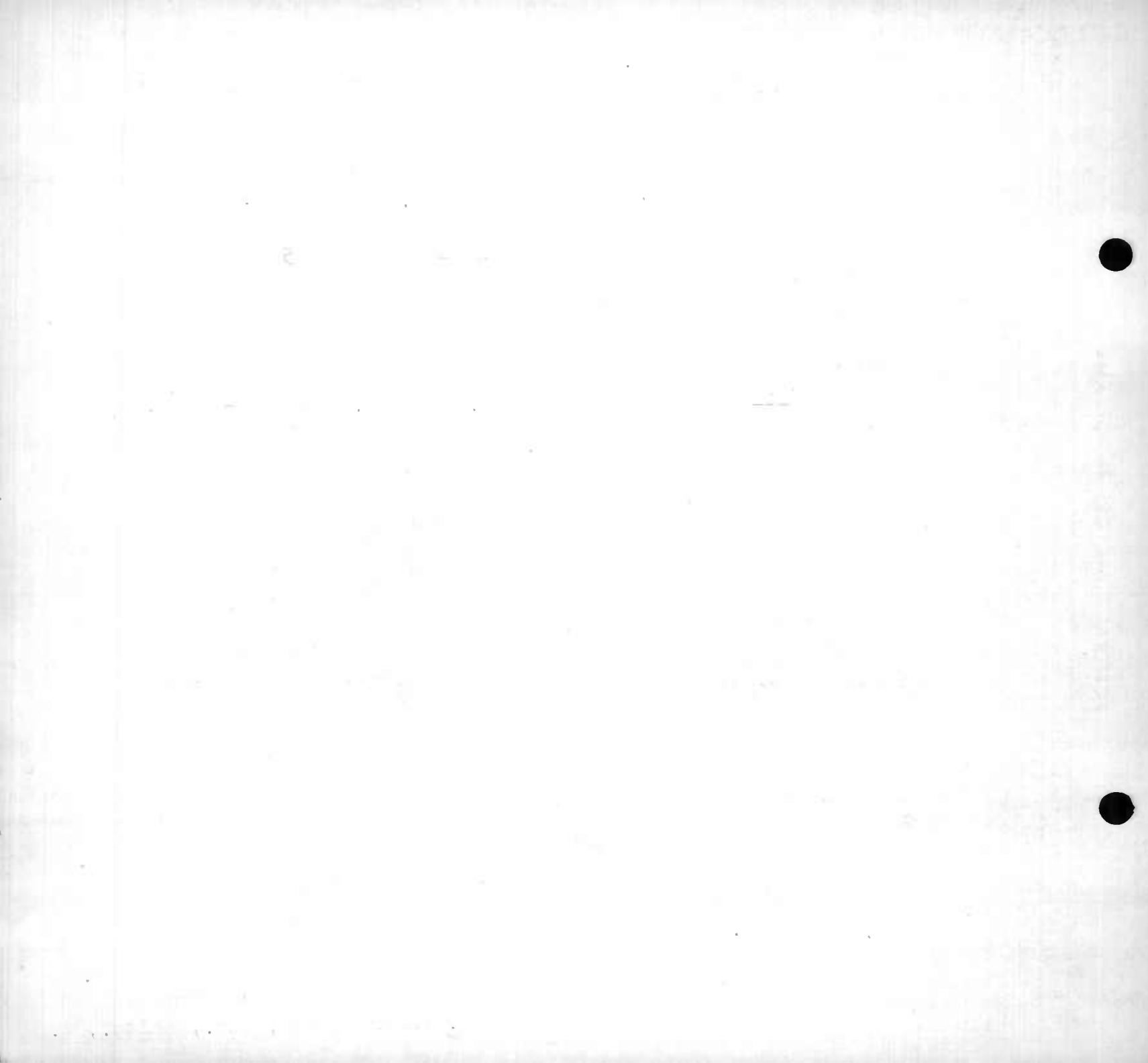




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

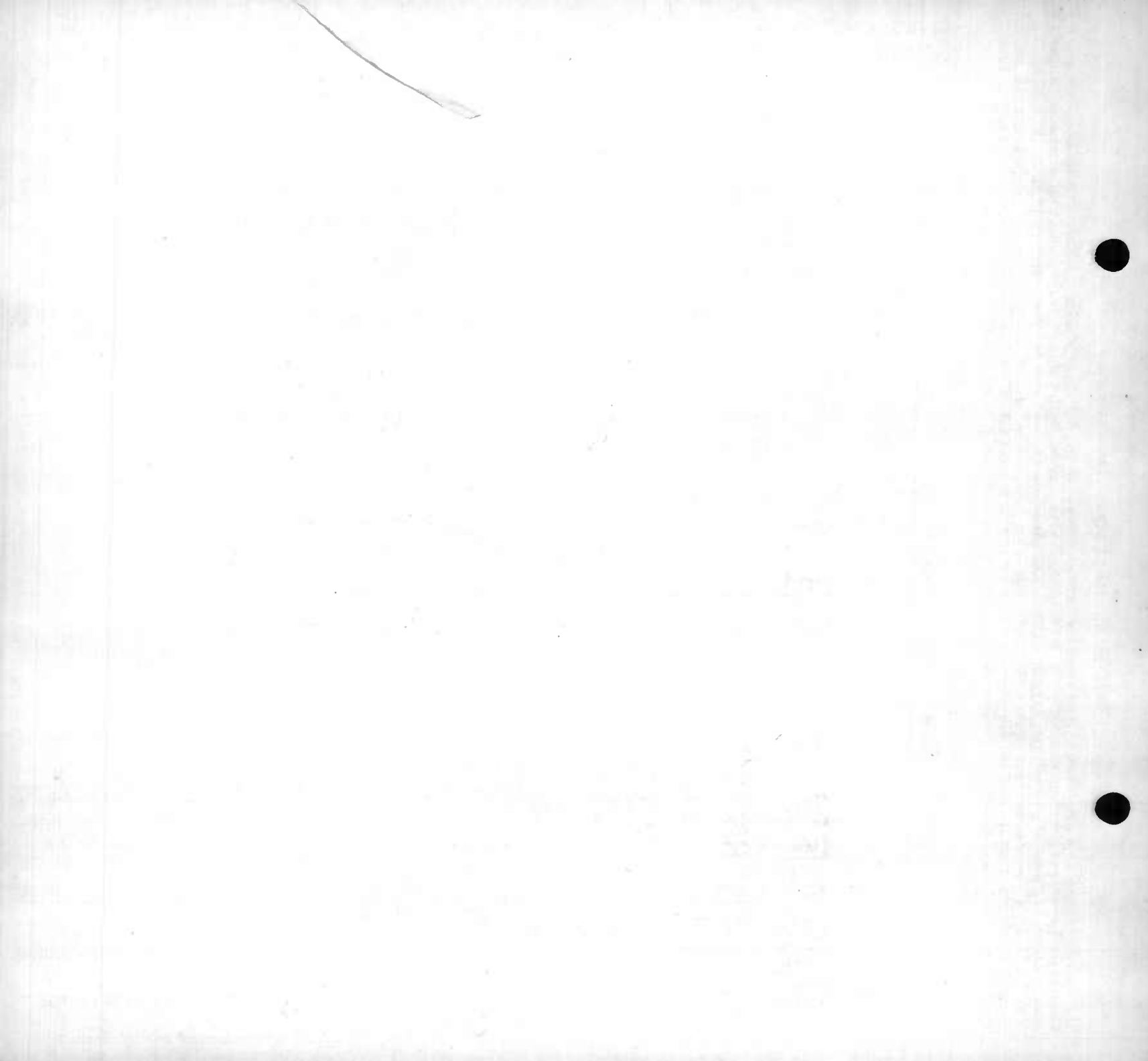
| BALTIMORE CITY HEALTH DEPARTMENT   |   |   |  | Registered No. <span style="float: right;">65 3988</span>   |  |
|--|---|---|--|---|--|
| BIRTH NO. <span style="float: right;">65 3988</span>   |   | <b>CERTIFICATE OF DEATH</b>   |  |   |  |
| M.E. CASE NO.  |   | 1. NAME OF DECEASED<br>(Type or Print) <span style="float: right;">(Mary L. Weinhardt)</span>   |  | 2. DATE AND HOUR OF DEATH<br><span style="float: right;">4-12-65 1:50 A.M.</span>                           |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <span style="float: right;">B. COUNTY</span><br><span style="float: right;">MARYLAND 1-02</span>  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><span style="float: right;">(If not in hospital or institution, give street address or location)</span><br><span style="float: right;">33</span><br><span style="float: right;">JOHNS HOPKINS HOSPITAL.</span>   |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><span style="float: right;">BALTIMORE, 24</span>   |  | D. STREET ADDRESS (If rural, give location)<br><span style="float: right;">512 S. POTOMAC ST.</span>        |  |
| 5. SEX<br><span style="float: right;">FEMALE</span>  | 6. RACE<br><span style="float: right;">WHITE</span> | 7. MARRIED, NEVER MARRIED<br>WIDOWED <span style="float: right;">DIVORCED (specify)</span><br><span style="float: right;">WIDOW</span>  | 8. DATE OF BIRTH<br><span style="float: right;">8-21-79</span> | 9. AGE (In years lost birth date)<br><span style="float: right;">85</span>                                  | If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="float: right;">housework</span>  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="float: right;">at Home</span>   |  | 11. BIRTHPLACE (State or foreign country)<br><span style="float: right;">Germany</span>                     |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="float: right;">USA</span>   |   | 13. FATHER'S NAME<br><span style="float: right;">HALLMANN, FREDRICK</span>  |  | 14. MOTHER'S MAIDEN NAME<br><span style="float: right;">Marie Louise Buchsath</span>                        |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="float: right;">no ---</span>  |   | 16. SOCIAL SECURITY NO.<br><span style="float: right;">none</span>  |  | 17. INFORMANT ADDRESS<br><span style="float: right;">Mr. Robert H. Weinhardt-512 S. Potomac St</span>       |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><span style="float: right;">422.1 I</span>   |   | CAUSE OF DEATH<br>(A) DUE TO <span style="float: right;">Toxic Changes resulting from bowel ischemia + gangrene</span><br>(B) DUE TO <span style="float: right;">Superior Mesenteric Artery Thrombosis</span><br>(C) <span style="float: right;">Arteriosclerotic Cardiovascular Disease</span> |  | INTERVAL BETWEEN ONSET AND DEATH<br><span style="float: right;">48 hr.</span>                               |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |   |   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |   |   |  |   |  |
| 19A. DATE OF OPERATION<br><span style="float: right;">34/11/65</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><span style="float: right;">Superior Mesenteric Artery Thrombosis</span>  |  | 20A. AUTOPSY? (Yes or No)<br><span style="float: right;">Yes</span>   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><span style="float: right;">NO</span>  |   |   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                                 |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that <del>(this hospital)</del> attended the deceased from <span style="float: right;">4/11/65</span> 19 <span style="float: right;">150 AM</span> to <span style="float: right;">4/12</span> 19 <span style="float: right;">65</span> , that <del>(we)</del> lost saw the deceased alive on <span style="float: right;">4/12</span> 19 <span style="float: right;">65</span> and that in <del>(our)</del> opinion death occurred on the date and hour end from the causes stated above. <del>(We)</del> <del>(did not)</del> view the body after death. |   |   |  |   |  |
| 23A. SIGNATURE<br><span style="float: right;">Robert D. Croom, M.D.</span>   |   | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><span style="float: right;">4/12/65</span>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="float: right;">DR. ROBERT D. CROOM</span>   |   | 23D. ADDRESS<br><span style="float: right;">Johns Hopkins Hosp. Balto Md</span>   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="float: right;">Burial</span>  |   | 24B. DATE<br><span style="float: right;">4/15/65</span>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><span style="float: right;">Loudon Park Cemetery</span>               |  |
| 24D. LOCATION<br><span style="float: right;">Baltimore, Maryland</span>  |   |   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |   | 25B. NAME OF REGISTRAR  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><span style="float: right;">H. Sander &amp; Sons, Inc., Balto., Md.</span> |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

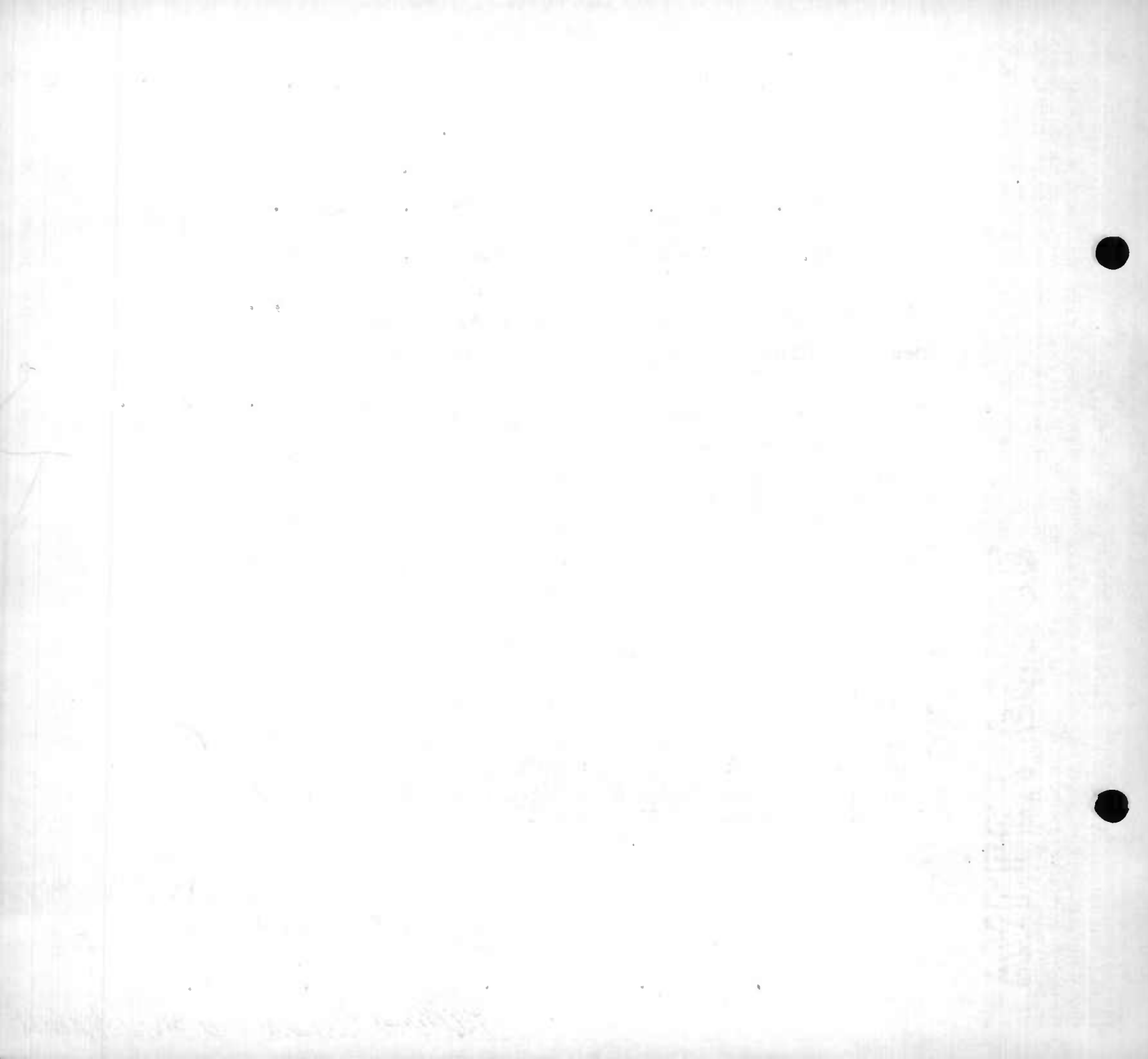
| Baltimore City Health Department   |  |   |  | Registered No. 65 3989  |  |
|--|--|---|--|---|--|
| BIRTH NO. 65 3989  |  | M.E. CASE NO.   |  | 1. NAME OF DECEASED (Type or Print) WARREN GARRISON                               |  |
| 2. DATE AND HOUR OF DEATH 4/12/65 2:22 P.M.  |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LUTHERAN   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 16-06   |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township) Baltimore |  |
| D. STREET ADDRESS (If rural, give location) 605 Gleneden Ave. 16-06  |  | 5. SEX MALE   |  | 6. RACE NEGRO   |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify) MARRIED   |  | 8. DATE OF BIRTH Apr. 30, 1889  |  | 9. AGE (In years last birthday) 75  |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired   |  | 10B. KIND OF BUSINESS OR INDUSTRY Janitor   |  | 11. BIRTHPLACE (State or foreign country) Novans, Md.                             |  |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 13. FATHER'S NAME Jerami Garrison   |  | 14. MOTHER'S MAIDEN NAME Helen Reynolds   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI   |  | 16. SOCIAL SECURITY NO. 207-22-7998   |  | 17. INFORMANT ADDRESS   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. If means the disease, injury or complication which caused death.)  |  | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES  |  | (A) DUE TO MASSIVE UPPER GASTROINTESTINAL BLEEDING - UNKNOWN ETIOLOGY.  |  | ONE HOUR  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.   |  |   |  |
|  |  | (C) CEREBRAL ARTERIOSCLEROSIS   |  |   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |  | BRONCHIAL ASTHMA  |  |   |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) NO  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)          |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                    |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 3/26 19 65 to 4/12 19 65, that (I) (we) last saw the deceased alive on 4/12 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE Oscar Fernandez   |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED  |  |
| 23C. PHYSICIAN'S NAME (Type) OSCAR FERNANDINI  |  | M.D.  |  | 23D. ADDRESS Lutheran Hospital  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE 4-16-65   |  | 24C. NAME OF CEMETERY OR CREMATORY Balt. Nat. Cem.                                |  |
| 24D. LOCATION (City, town, or county) (State) Balto. Md.   |  | 25A. DATE REC'D BY HEALTH DEPT. APR 14 1965   |  | 25B. NAME OF REGISTRAR E. O. Johnson  |  |
| 25C. FUNERAL DIRECTOR ADDRESS  |  | 1000 Brantley Ave.  |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3990   |         |  |                          | BALTIMORE CITY HEALTH DEPARTMENT   |                               | Registered No. 65 3990   |                       |
|---|---------|--|--------------------------|--|-------------------------------|--|-----------------------|
| M.E. CASE NO.   |         |  |                          | CERTIFICATE OF DEATH   |                               |  |                       |
| 1. NAME OF DECEASED<br>(Type or Print)  |         |  |                          | 2. DATE AND HOUR OF DEATH  |                               |  |                       |
| Maggie Chalmers Simpson   |         |  |                          | April 10, 1965 9:37 A.M.   |                               |  |                       |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |         |  |                          | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                               |  |                       |
| FULL NAME OF HOSPITAL OR INSTITUTION  |         | (If not in hospital or institution, give street address or location)                     |                          | A. STATE   |                               | B. COUNTY  |                       |
|   |         | 240 N. Amity St.   |                          | Md.  |                               | X  |                       |
|   |         |  |                          | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |                               |  |                       |
|   |         |  |                          | Balto. 18-01   |                               |  |                       |
|   |         |  |                          | D. STREET ADDRESS (If rural, give location)  |                               |  |                       |
|   |         |  |                          | 240 N. Amity St.   |                               |  |                       |
| 5. SEX  | 6. RACE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)                                   | 8. DATE OF BIRTH         | 9. AGE (In years last birthday)  | If Under 1 Yr. Months         |  | If Under 24 Hrs. Days |
| Female  | Col.    | Widow  | July 10, 1899            | 65   |                               |  |                       |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                          | 11. BIRTHPLACE (State or foreign country)  |                               | 12. CITIZEN OF WHAT COUNTRY?   |                       |
| Housewife   |         |  |                          | S.C.   |                               |  |                       |
| 13. FATHER'S NAME   |         |  | 14. MOTHER'S MAIDEN NAME |  |                               |  |                       |
| Pres Rice   |         |  | Ida                      |  |                               |  |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS         |  |                       |
| no  |         |  |                          |  | Dennis Simpson 5 N. Bruce St. |  |                       |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |  |                          | CAUSE OF DEATH   |                               | INTERVAL BETWEEN ONSET AND DEATH                                     |                       |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  |                          | A. MYOCARDIAL INFARCT 7 days   |                               |  |                       |
| ANTECEDENT CAUSES   |         |  |                          | B. CANDIDIASIS curd disease 4 years  |                               |  |                       |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  |                          | C.   |                               |  |                       |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |         |  |                          |  |                               |  |                       |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                          | 20A. AUTOPSY? (Yes or No)  |                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |                       |
|   |         |  |                          | No   |                               |  |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                          | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                               |  |                       |
|   |         |  |                          |  |                               |  |                       |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                          | 21F. HOW DID INJURY OCCUR?   |                               |  |                       |
|   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                          |  |                               |  |                       |
| 22. I certify that (I) (this hospital) attended the deceased from March 9 1961 to April 10 1965, that (I) (we) last saw the deceased alive on April 2 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                          |  |                               |  |                       |
| 23A. SIGNATURE  |         |  |                          | 23B. DATE SIGNED   |                               |  |                       |
| William H. Watts  |         |  |                          | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                               | 4/14-65  |                       |
| 23C. PHYSICIAN'S NAME (Type)  |         |  |                          | 23D. ADDRESS   |                               |  |                       |
| William H. Watts  |         |  |                          | 515 N. Arlington Ave. Balto. Md.   |                               |  |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE  |                          | 24C. NAME OF CEMETERY OR CREMATORY   |                               | 24D. LOCATION (City, town, or county) (State)                        |                       |
| Burial  |         | Apr. 14/65   |                          | Mt. Auburn Cem.  |                               | Balto. Md.   |                       |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                          | 25C. FUNERAL DIRECTOR  |                               | ADDRESS  |                       |
| APR 14 1965   |         | R. E. E. S. S. S. S.   |                          | Williams Funeral Home 3199 N. Broadway   |                               |  |                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3991  |  |                  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | Registered No. 65 3991  |  |  |  |
|--|--|------------------|--|--|--|---|--|---|--|--|--|
| M.E. CASE NO.  |  |                  |  | CERTIFICATE OF DEATH   |  |   |  |   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Preston Charlie R.</u>   |  |                  |  | 2. DATE AND HOUR OF DEATH<br><u>April 9, 1965</u> <u>7<sup>30</sup></u> <u>A</u> M.  |  |   |  |   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |                  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  |  |   |  |   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |  |                  |  | A. STATE <u>MARYLAND</u> B. COUNTY <u>Baltimore</u>  |  |   |  |   |  |  |  |
|  |  |                  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)  |  |   |  |   |  |  |  |
|  |  |                  |  | D. STREET ADDRESS (If rural, give location)  |  |   |  |   |  |  |  |
|  |  |                  |  | <u>1215 W. FRANKLIN ST.</u> <u>#23</u>   |  |   |  |   |  |  |  |
| 5. SEX <u>Male</u>   |  | 6. RACE <u>C</u> |  | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><u>Single</u>  |  | 8. DATE OF BIRTH<br><u>Feb 14, 1905</u> |  | 9. AGE (In years last birthday)<br><u>60</u>  |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Presser</u>  |  |                  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>-</u>  |  |   |  | 11. BIRTHPLACE (State or foreign country)<br><u>Virginia</u>  |  |  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  |                  |  | 13. FATHER'S NAME<br><u>Ernest Preston</u>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>Ellena Nicklos</u>   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |  |                  |  | 16. SOCIAL SECURITY NO.  |  |   |  | 17. INFORMANT<br><u>Estella Carter</u> ADDRESS <u>2732 Fisk Rd</u>  |  |  |  |
| 18. <u>420.11</u>  |  |                  |  | CAUSE OF DEATH   |  |   |  | INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) |  |                  |  | (A) <u>Acute myocardial infarction</u><br>DUE TO   |  |   |  |   |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |                  |  | (B) <u>Arterio-sclerotic heart</u><br>DUE TO   |  |   |  |   |  |  |  |
|  |  |                  |  | (C) <u>disease</u>   |  |   |  |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                  |  |  |  |   |  |   |  |  |  |
| 19A. DATE OF OPERATION   |  |                  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20A. AUTOPSY? (Yes or No)<br><u>YES</u>   |  |  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>NO</u>  |  |                  |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |                  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)  |  |   |  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/> |  |  |  |
| 21F. HOW DID INJURY OCCUR?   |  |                  |  | 22. I certify that (this hospital) attended the deceased from <u>April 9</u> 19 <u>65</u> to <u>April 9</u> 19 <u>65</u> , that (I) <u>two</u> lost saw the deceased alive on <u>April 9</u> 19 <u>65</u> and that in (my) <u>four</u> opinion death occurred on the date and hour and from the causes stated above. (I) <u>two</u> (did) (did not) view the body after death. |  |   |  |   |  |  |  |
| 23A. SIGNATURE<br><u>[Signature]</u>   |  |                  |  | M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |  |   |  | 23B. DATE SIGNED<br><u>April 9/65</u>   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>BENIGNO M. OTEY ZA</u>  |  |                  |  | 23D. ADDRESS<br><u>5506-A BELCREST RD, BALT. 21206</u>   |  |   |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |                  |  | 24B. DATE<br><u>4/15/65</u>  |  |   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>St Lukes Cem Balto Md</u>  |  |  |  |
| 24D. LOCATION (City, town, or county) (State)<br><u>Balto Md</u>   |  |                  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 14 1965</u>  |  |   |  | 25B. NAME OF REGISTRAR<br><u>[Signature]</u>  |  |  |  |
| 25C. FUNERAL DIRECTOR<br><u>[Signature]</u>  |  |                  |  | ADDRESS<br><u>3193 Schroeder St</u>  |  |   |  |   |  |  |  |

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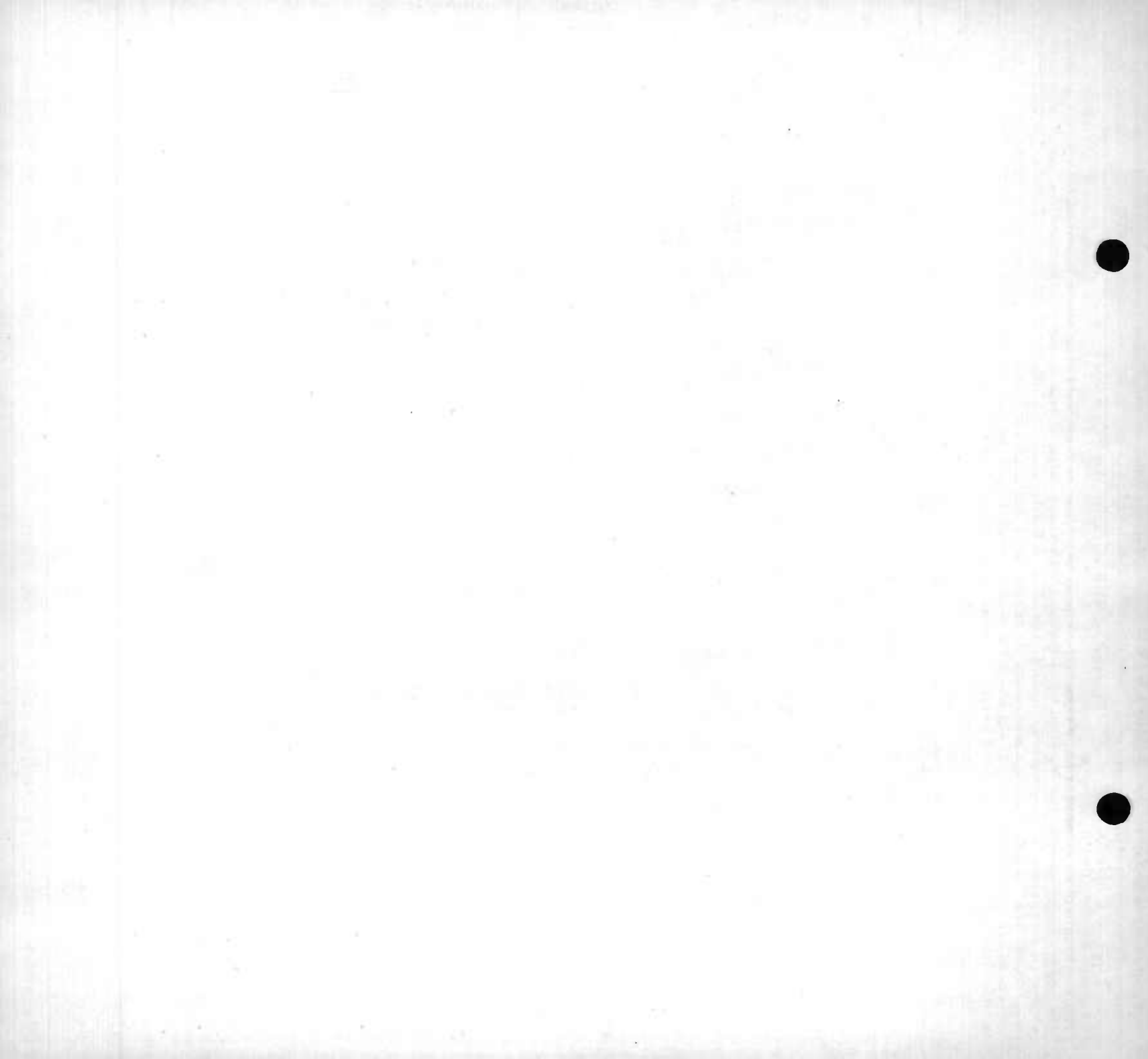
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# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

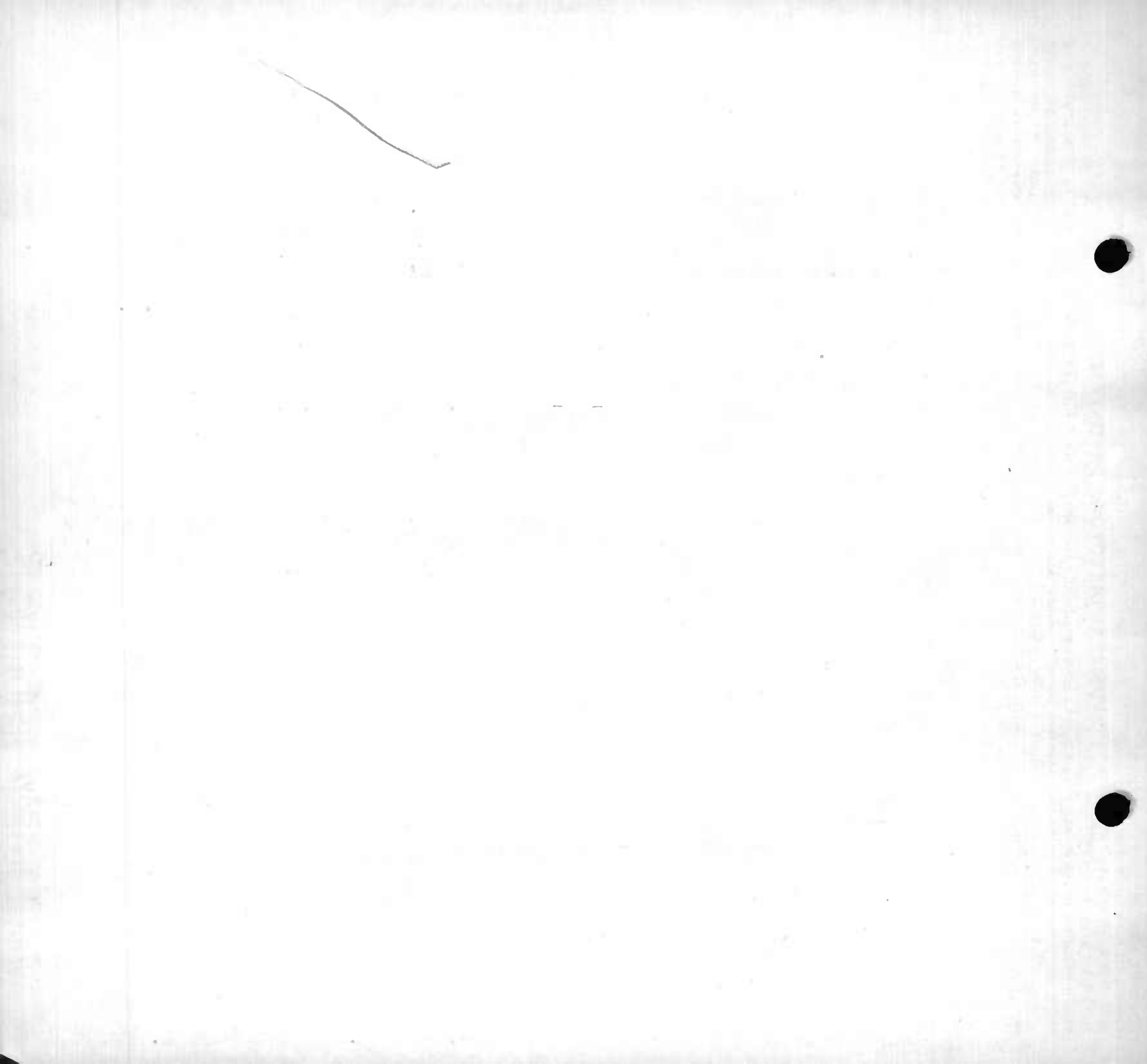
| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | Registered No. <span style="font-size: 1.2em;">65 3992</span>   |  |
|--|--|---|--|---|--|
| <b>BIRTH NO.</b> <span style="font-size: 1.2em;">65 3992</span><br><b>M.E. CASE NO.</b><br><b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="font-size: 1.1em;">Lucress Raynor</span>   |  | <b>2. DATE AND HOUR OF DEATH</b><br><span style="font-size: 1.2em;">April 9, 1965</span> <span style="float: right;">M.</span>  |  |   |  |
| <b>3. PLACE OF DEATH IN BALTIMORE, MARYLAND</b><br><br><div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br/> <span style="font-size: 1.1em;">2316 Whittier Ave</span> </div> <div>                     (If not in hospital or institution, give street address or location)                 </div> </div>  |  | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.1em;">Maryland</span><br>B. COUNTY<br><br><b>C. CITY OR TOWN</b> (If outside city limits, write RURAL and give township)<br><span style="font-size: 1.1em;">Baltimore</span><br><b>D. STREET ADDRESS</b> (If rural, give location)<br><span style="font-size: 1.1em;">2316 Whittier Ave</span> |  |   |  |
| <b>5. SEX</b><br><span style="font-size: 1.1em;">Female</span>   | <b>6. RACE</b><br><span style="font-size: 1.1em;">Colored</span> | <b>7. MARRIED, NEVER MARRIED</b><br>WIDOWED, DIVORCED (specify)<br><span style="font-size: 1.1em;">Widowed</span>   | <b>8. DATE OF BIRTH</b><br><span style="font-size: 1.1em;">Dec 23, 1881</span>     | <b>9. AGE</b> (In years last birthday)<br><span style="font-size: 1.1em;">83</span>   | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.1em;">Domestic</span> |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.1em;">Domestic</span>  |  | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><span style="font-size: 1.1em;">Private Family</span>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><span style="font-size: 1.1em;">Norfolk, Virginia</span>  | <b>12. CITIZEN OF WHAT COUNTRY?</b><br><span style="font-size: 1.1em;">U.S.A</span>  |
| <b>13. FATHER'S NAME</b><br><span style="font-size: 1.1em;">Charles Douglass</span>  |  |   | <b>14. MOTHER'S MAIDEN NAME</b><br><span style="font-size: 1.1em;">Pollie ?</span> |   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b><br>(Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.1em;">No</span>  |  | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT</b> <span style="font-size: 1.1em;">Mrs. Elizabeth Bourne</span> <b>ADDRESS</b> <span style="font-size: 1.1em;">2316 Whittier Ave</span> |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, osteinemia, etc. It means the disease, injury or complication which caused death.)<br><br><b>ANTECEDENT CAUSES</b><br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | <b>CAUSE OF DEATH</b><br><span style="font-size: 1.2em;">Hypertensive Cardiovascular Disease</span><br>(A) DUE TO<br><br>(B) DUE TO<br><br>(C)  |  | <b>INTERVAL BETWEEN ONSET AND DEATH</b><br><span style="font-size: 1.2em;">4 yrs</span>   |  |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.</b>   |  |   |  |   |  |
| <b>19A. DATE OF OPERATION</b>  |  | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |  | <b>20A. AUTOPSY?</b> (Yes or No)<br><span style="font-size: 1.1em;">No</span>   |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)   |  | <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)   |  |
| <b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)   |  | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.1em;">6-27-60</span> <b>19</b> <b>to</b> <span style="font-size: 1.1em;">4-9-</span> <b>19</b> <span style="font-size: 1.1em;">64</span> , <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.1em;">4-7-</span> <b>19</b> <span style="font-size: 1.1em;">65</span> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |  |   |  |   |  |
| <b>23A. SIGNATURE</b><br><span style="font-size: 1.2em;">Mauro Adams</span> <b>M.D.</b>  |  |   |  | <b>23B. DATE SIGNED</b><br><span style="font-size: 1.2em;">4-12-65</span>   |  |
| <b>23C. PHYSICIAN'S NAME</b> (Type)<br><span style="font-size: 1.2em;">MAURICE ADAMS</span> <b>M.D.</b>  |  | <b>23D. ADDRESS</b><br><span style="font-size: 1.2em;">238 N Carey St Baltimore</span>  |  |   |  |
| <b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br><span style="font-size: 1.1em;">Burial</span>   |  | <b>24B. DATE</b><br><span style="font-size: 1.1em;">4/14/65</span>  |  | <b>24C. NAME of CEMETERY or CREMATORY</b><br><span style="font-size: 1.1em;">Carver Memorial Park</span>  |  |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><span style="font-size: 1.1em;">Laurel Maryland</span>   |  | <b>25A. DATE REC'D BY HEALTH DEPT.</b>  |  |   |  |
| <b>25B. NAME OF REGISTRAR</b><br><span style="font-size: 1.1em;">Herbert E. Jutter</span>  |  | <b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b><br><span style="font-size: 1.1em;">3035 W. North Ave</span>   |  |   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

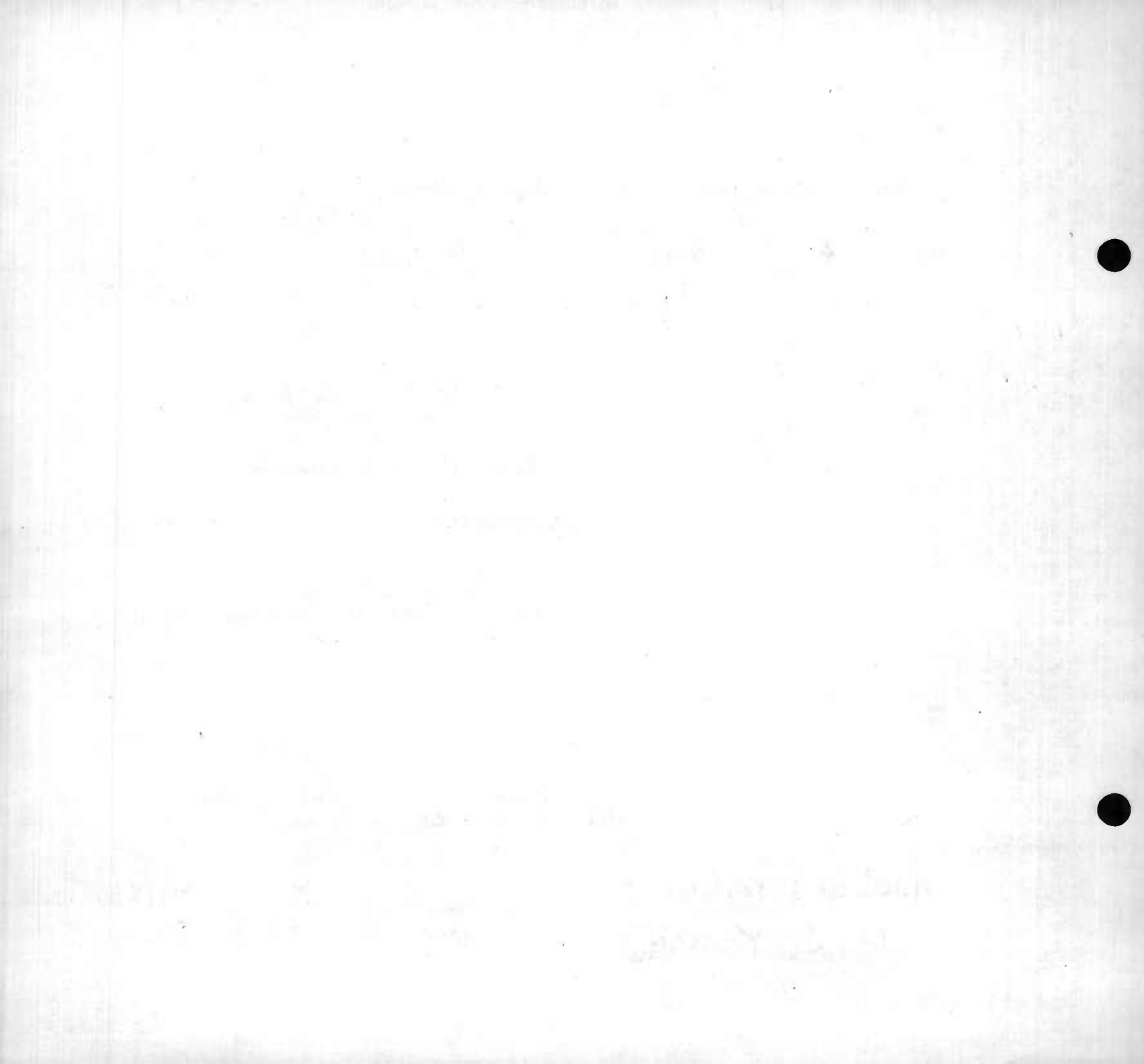
| BALTIMORE CITY HEALTH DEPARTMENT   |                           |  |  | BIRTH NO. 65 3993  |   | CERTIFICATE OF DEATH  |  | Registered No. 65 3993   |  |
|--|---------------------------|--|--|--|---|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Clara Eliza Harris</u>   |                           |  |  | 2. DATE AND HOUR OF DEATH<br><u>April 9, 1965</u> M.   |   |   |  |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>Provident Hospital</u>   |                           |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>16-02</u><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><u>Baltimore</u><br>D. STREET ADDRESS (If rural, give location)<br><u>934 N. Stricker Street</u> |   |   |  |  |  |
| 5. SEX<br><u>Female</u>  | 6. RACE<br><u>Colored</u> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><u>Widowed</u>                             | 8. DATE OF BIRTH<br><u>Feb 20, 1891</u>                  | 9. AGE (In years last birthday)<br><u>74</u>   | If Under 1 Yr. Months: Days: Hours: Min.                                |   | If Under 24 Hrs. Min.                        |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Dietic Clerk</u>   |                           |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Drug Company</u> |  | 11. BIRTHPLACE (State or foreign country)<br><u>Baltimore, Maryland</u> |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A</u> |  |  |
| 13. FATHER'S NAME<br><u>Charles H. Young</u>   |                           |  |  | 14. MOTHER'S MAIDEN NAME<br><u>Henrietta Harden</u>  |   |   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>No</u>  |                           |  | 16. SOCIAL SECURITY NO.<br><u>218-22-2263</u>            |  | 17. INFORMANT<br><u>Mr. Raymond A.C. Young</u>                          |   | ADDRESS<br><u>2323 Druid Hill Ave</u>        |  |  |
| 18. <u>420.01</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                      |                           |  |  | CAUSE OF DEATH<br>(A) <u>BRONCHO PNEUMONIA</u><br>DUE TO<br>(B) <u>ARTEROSCLEROTIC-HYPERTENSIVE</u><br>DUE TO <u>HEART DISEASE</u><br>(C) <u>GENERALIZED ARTERIOSCLEROSIS</u>  |   |   |  | INTERVAL BETWEEN ONSET AND DEATH<br><u>30 DAYS</u><br><u>25 yrs</u><br><u>25 yrs</u> |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                           |  |  |  |   |   |  |  |  |
| 19A. DATE OF OPERATION<br><u>D</u>   |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?              |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |   |   |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |   |   |  |  |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>May 25, 1964</u> to <u>April 1965</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>March 2, 1965</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) view the body after death. |                           |  |  |  |   |   |  |  |  |
| 23A. SIGNATURE<br><u>Ernest C. Wagoner</u> M.D.  |                           |  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>  |   | 23B. DATE SIGNED<br><u>9 April 65</u>   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Ernest C. Wagoner</u>   |                           |  |  | 23D. ADDRESS<br><u>2329 HARVEY AVE BART. LD.</u>   |   |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |                           | 24B. DATE<br><u>4/13/65</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>Mount Zion Cemetery</u>   |   | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore County Maryland</u> |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>APR 14 1965</u>  |                           | 25B. NAME OF REGISTRAR<br><u>Robert E. G. Gutter</u>   |  | 25C. FUNERAL DIRECTOR<br><u>Harbert E. Gutter</u>  |   | ADDRESS<br><u>3035 W. North Ave</u>   |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

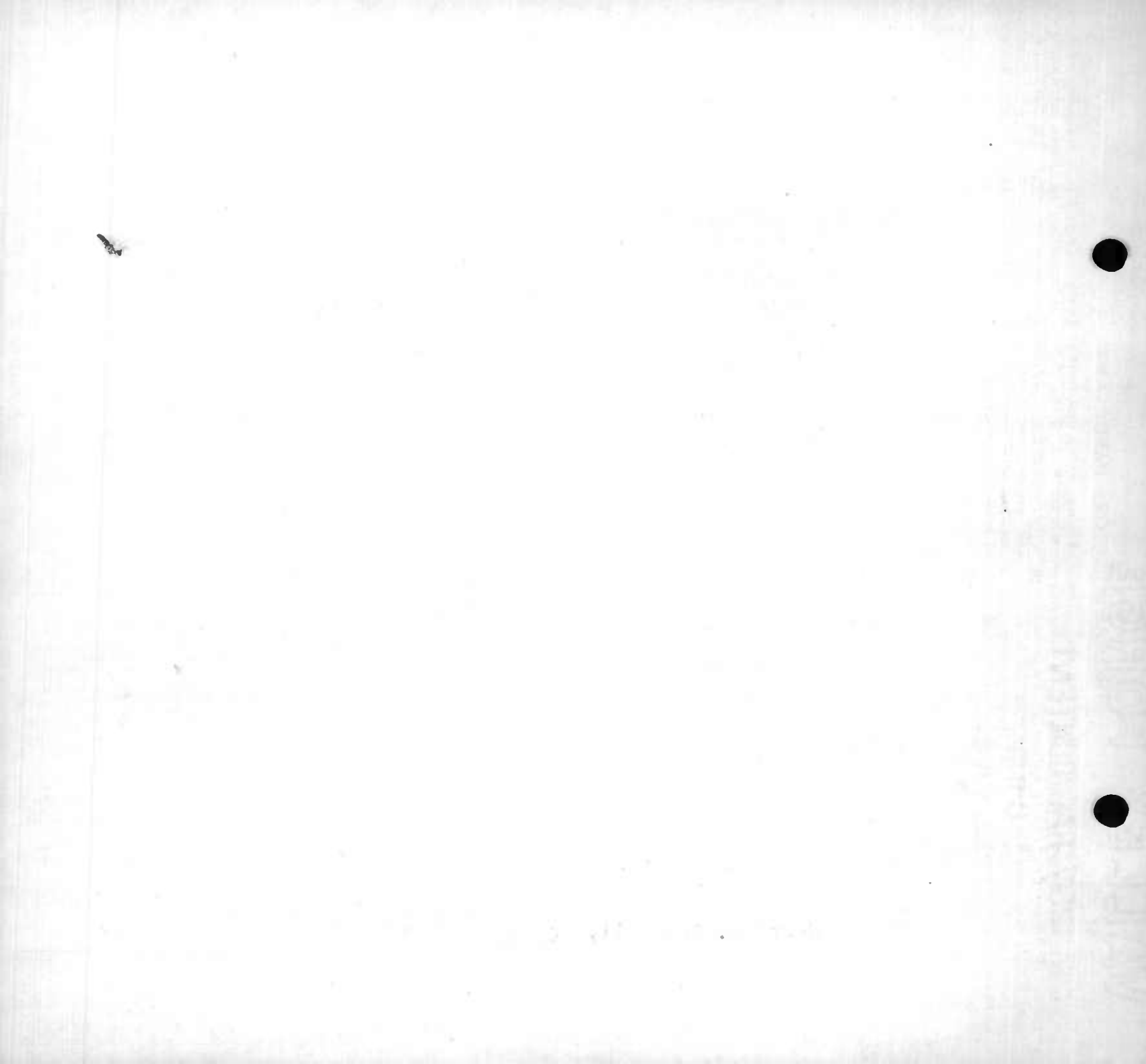
| BIRTH NO. 65 3994   |                           |  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | Registered No. 65 3994  |                       |
|---|---------------------------|--|--|--|--|---|-----------------------|
| M.E. CASE NO.   |                           |  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>JESSE MOOREHEAD</b>  |  |   |                       |
| 2. DATE AND HOUR OF DEATH<br><b>4/12/65 11:55 A.M.</b>  |                           |  |  |  |  |   |                       |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>SINAI HOSPITAL</b>  |                           |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE CITY</b><br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE 15-04</b><br>D. STREET ADDRESS (If rural, give location)<br><b>2221 N. Pulaski Street</b> |  |   |                       |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>Colored</b> | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br><b>MARRIED</b>                             |  | 8. DATE OF BIRTH<br><b>6/17/87</b>   | 9. AGE (In years lost birthday)<br><b>77</b> | If Under 1 Yr. Months: Days: Hours: Min.                                    | If Under 24 Hrs. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CHAUFFEUR</b>   |                           | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PRIVATE FAMILY</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>WATER VALLEY, MISS</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A</b>                                |                       |
| 13. FATHER'S NAME<br><b>?</b>   |                           | 14. MOTHER'S MAIDEN NAME<br><b>ELLA ?</b>  |  |  |  |   |                       |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                           | 16. SOCIAL SECURITY NO.<br><b>212-12-5361</b>  |  | 17. INFORMANT<br><b>MRS. Naomi MOOREHEAD</b>   |  | ADDRESS<br><b>2221 N. Pulaski Street</b>                                    |                       |
| 18. <b>491X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Aspiration Pneumonitis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Arteriosclerotic Cardiovascular Disease</b><br><b>Pulmonary emphysema, GI bleeding? cause</b> |                           |  |  | (A) DUE TO<br><b>Aspiration Pneumonitis</b>  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>24 hrs.</b>                          |                       |
|   |                           |  |  | (B) DUE TO<br><b>Cachexia</b>  |  | <b>3-4-6 MONTHS</b>   |                       |
|   |                           |  |  | (C) DUE TO   |  |   |                       |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.  |                           |  |  |  |  |   |                       |
| 19A. DATE OF OPERATION<br><b>0</b>  |                           | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |                       |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notably medical examiner)  |                           | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |                       |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                           | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |                       |
| 22. I certify that (I) (this hospital) attended the deceased from <b>4/7</b> 19 <b>65</b> to <b>4/12</b> 19 <b>65</b> , that (I) (we) last saw the deceased alive on <b>4/12</b> 19 <b>65</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                           |  |  |  |  |   |                       |
| 23A. SIGNATURE<br><b>Melvin J. Kordon</b>   |                           |  |  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |  | 23B. DATE SIGNED<br><b>4/12/65</b>  |                       |
| 23C. PHYSICIAN'S NAME (Type)<br><b>M. J. KORDON</b>   |                           |  |  | 23D. ADDRESS<br>M.D. <b>SINAI HOSPITAL OF BALTIMORE</b>  |  |   |                       |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                           | 24B. DATE<br><b>4/14/65</b>  |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>MOUNT CALVARY Cem.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>ANNE ARUNDEL Co, MD</b> |                       |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>   |                           | 25B. NAME OF REGISTRAR<br><b>Robert E. Stachura</b>  |  | 25C. FUNERAL DIRECTOR<br><b>HERBERT E. WUTTER</b>  |  | ADDRESS<br><b>3035 W. NORTH AVE</b>   |                       |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. 65 3995   |                         |  |   | BALTIMORE CITY HEALTH DEPARTMENT  |  | Registered No. 65 3995  |  |
|---|-------------------------|--|---|---|--|---|--|
| M.E. CASE NO.   |                         |  |   | CERTIFICATE OF DEATH  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>WILLIAM JOHN NOAH</b>   |                         |  |   | 2. DATE AND HOUR OF DEATH<br><b>APRIL 10, 1965 9:25 AM</b>  |  |   |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND  |                         |  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>UNIVERSITY HOSPITAL</b>  |                         | (If not in hospital or institution, give street address or location)                                   |   | A. STATE<br><b>MD</b>   |  | B. COUNTY<br><b>26-17</b>   |  |
|   |                         |  |   | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br><b>BALTIMORE ZONE 24</b>                             |  |   |  |
|   |                         |  |   | D. STREET ADDRESS (If rural, give location)<br><b>4505 EASTERN AVE</b>  |  |   |  |
| 5. SEX<br><b>M</b>  | 6. RACE<br><b>white</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (specify)<br><b>wid.</b>                                  | 8. DATE OF BIRTH<br><b>JAN 13, 1894</b> | 9. AGE (In years last birthday)<br><b>70</b>  | If Under 1 Yr. Months Days (f Under 24 Hrs. Hours Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>FURNACE HELPER - RETIRED</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY  |   | 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                            |  |
| 13. FATHER'S NAME<br><b>PAUL NOAH</b>   |                         |  |   | 14. MOTHER'S MAIDEN NAME<br><b>ANNA -</b>   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>-</b>  |   | 17. INFORMANT<br><b>GEORGE NOAH 1907 CRAFTON AVE</b>  |  | ADDRESS   |  |
| 18. <b>603X14260X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><b>UREMIA, OLIGURIA</b>  |                         |  |   | CAUSE OF DEATH  |  | INTERVAL BETWEEN ONSET AND DEATH<br><b>15-04</b>                      |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |  |   | (B) <b>BILATERAL URETERAL OBSTRUCTION</b>   |  |   |  |
|   |                         |  |   | (C) <b>CARCINOMA OF COLON</b>   |  |   |  |
| II  |                         |  |   |   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br><b>DIABETES MELITUS</b>   |                         |  |   |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)                |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>April 6, 1965</b> to <b>April 10, 1965</b> , that (I) (we) last saw the deceased alive on <b>April 10, 1965</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |  |   |   |  |   |  |
| 23A. SIGNATURE<br><b>Edward W. Campbell, Jr.</b> M.D.   |                         |  |   | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br><b>April 10, 1965</b>                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Edward W. Campbell, Jr</b> M.D.  |                         |  |   | 23D. ADDRESS  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>4-13-65</b>  |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>SACRED HEART CEMETERY</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE MD.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>APR 14 1965</b>   |                         | 25B. NAME OF REGISTRAR<br><b>R. G. E. S. S. S.</b>   |   | 25C. FUNERAL DIRECTOR<br><b>DOBROWSKI DRIVE</b>   |  | ADDRESS<br><b>BALTIMORE ST</b>  |  |

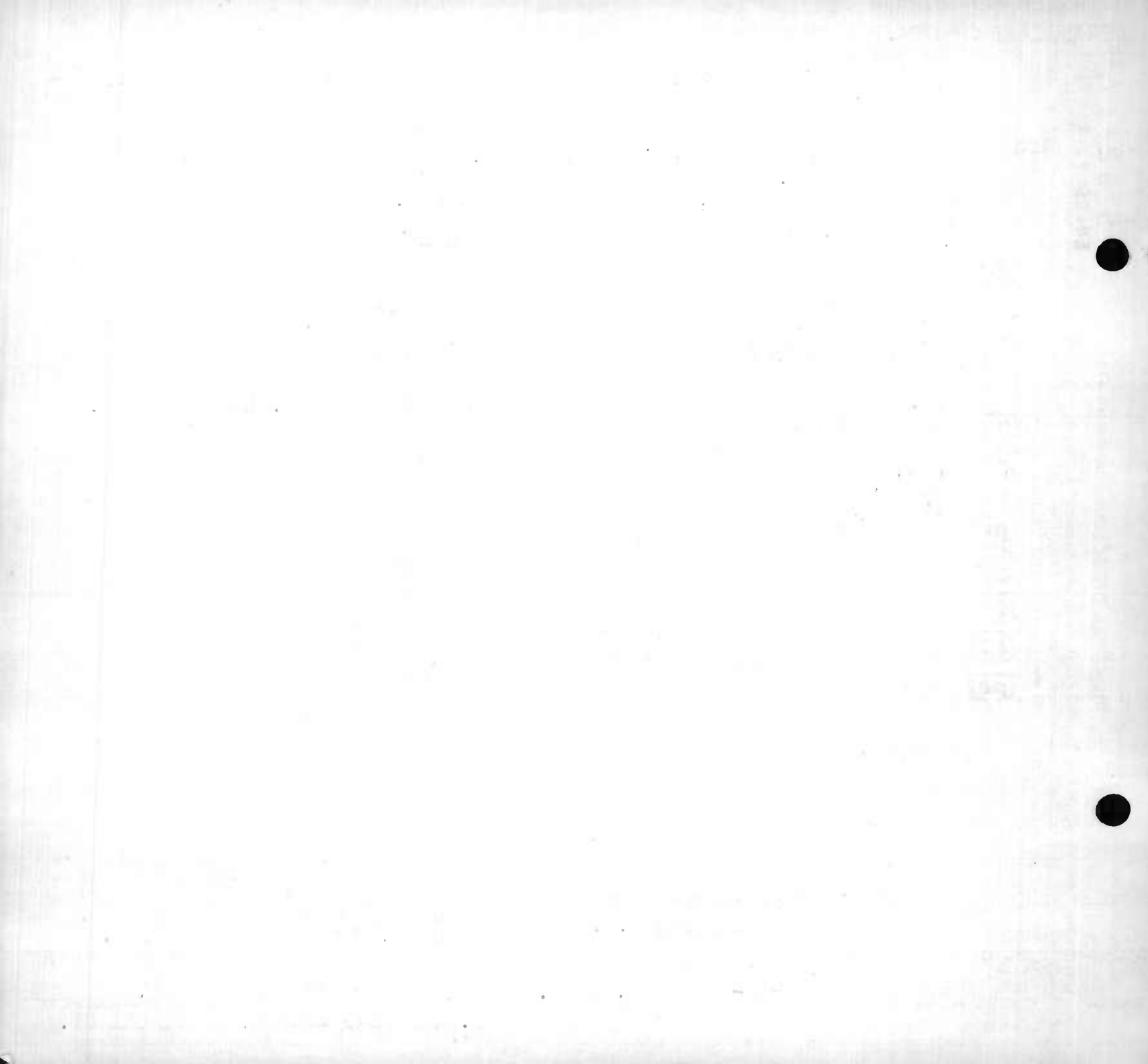




# FUNERAL DIRECTOR: IMPORTANT

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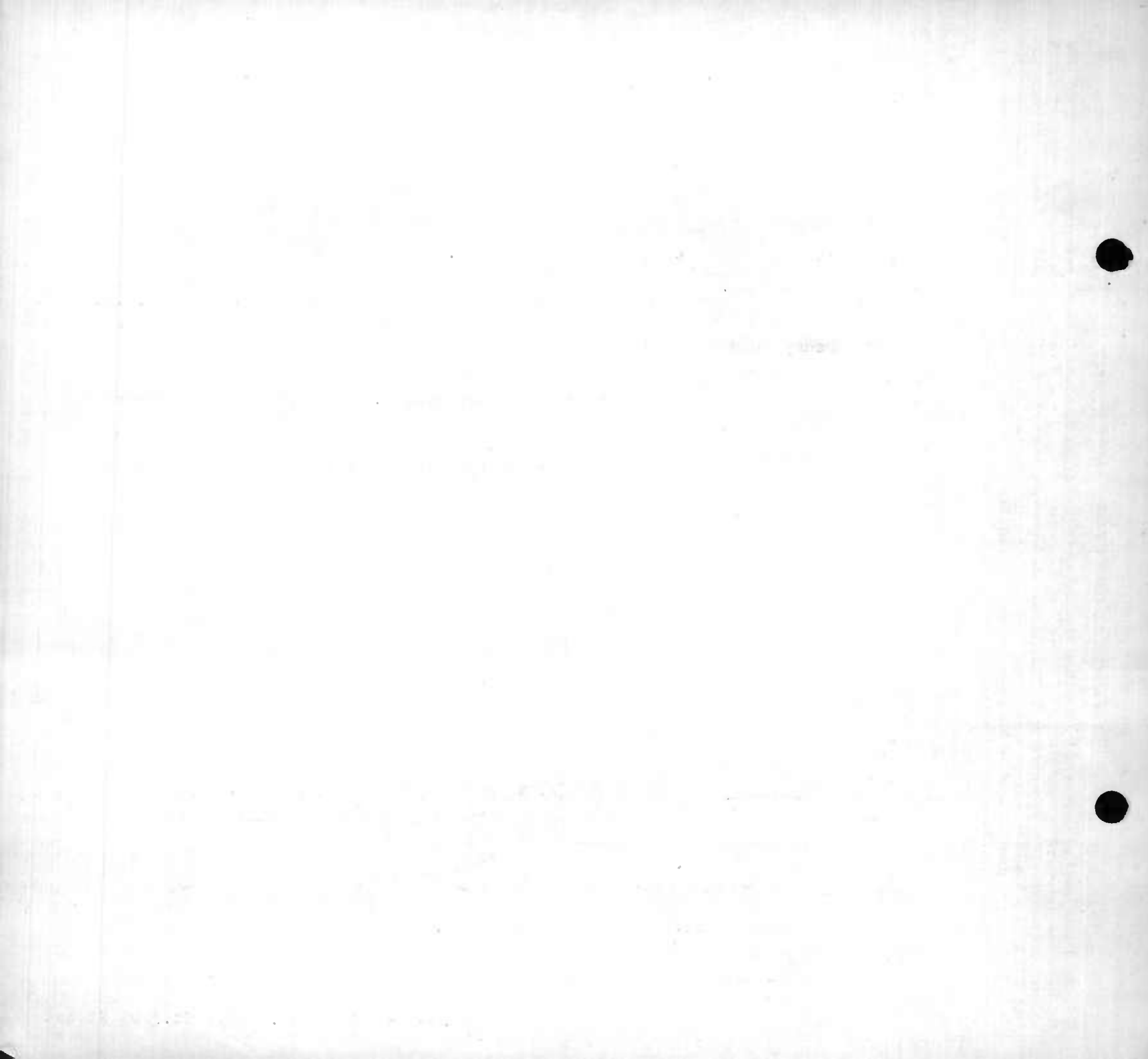
|  |              |  |                             |  |   |
|--|--------------|--|-----------------------------|--|---|
| BIRTH NO. 65 3396  |              | BALTIMORE CITY HEALTH DEPARTMENT   |                             | Registered No. 65 3396   |   |
| M.E. CASE NO.  |              | CERTIFICATE OF DEATH   |                             |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) CECIL KNICELY   |              | 2. DATE AND HOUR OF DEATH<br>4-10-65 9:30 A.M.   |                             |  |   |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |              | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |                             |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>THE JOHNS HOPKINS HOSPITAL<br>601 N. BROADWAY<br>BALTIMORE 5, MD  |              | A. STATE B. COUNTY<br>MARYLAND 6-02  |                             |  |   |
|  |              | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>BALTIMORE   |                             |  |   |
|  |              | D. STREET ADDRESS (If rural, give location)<br>150 N. LAKEWOOD AVE   |                             |  |   |
| 5. SEX<br>M  | 6. RACE<br>W | 7. MARRIED, NEVER MARRIED<br>WIDOWED (specify)   | 8. DATE OF BIRTH<br>12-4-09 | 9. AGE (In years lost day)<br>55   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>CAB DRIVER  |              | 10B. KIND OF BUSINESS OR INDUSTRY  |                             | 11. BIRTHPLACE (State or foreign country)<br>VIRGINIA                    |   |
| 13. FATHER'S NAME<br>ELIJAH KNICELY  |              | 14. MOTHER'S MAIDEN NAME<br>CORA JANE  |                             | 12. CITIZEN OF WHAT COUNTRY?   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>WW 2   |              | 16. SOCIAL SECURITY NO.  |                             | 17. INFORMANT ADDRESS<br>VADA HARMAN 150 N. LAKEWOOD AVE.                |   |
| 18. 331X I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. |              | CAUSE OF DEATH<br>(A) RESPIRATORY ARREST<br>DUE TO<br>(B) CVA (BRAIN STEM)<br>DUE TO<br>(C) HYPERTENSION                             |                             | INTERVAL BETWEEN ONSET AND DEATH<br>5 mins.                              |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |              |  |                             |  |   |
| 19A. DATE OF OPERATION<br>2  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                             | 20A. AUTOPSY? (Yes or No)<br>Yes   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |              | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                             | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 4/9 1965 to 4/10 1965, that (I) (we) last saw the deceased alive on 9:30 AM 4/10 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.                                     |              |  |                             |  |   |
| 23A. SIGNATURE<br>Michael Lesch  |              | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                             | 23B. DATE SIGNED<br>4/10/65  |   |
| 23C. PHYSICIAN'S NAME (Type)<br>MICHAEL LESCH M.D.   |              | 23D. ADDRESS<br>THE JOHNS HOPKINS HOSPITAL<br>601 N. BROADWAY - BALTO, MD.   |                             |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |              | 24B. DATE<br>4-13-65   |                             | 24C. NAME OF CEMETERY or CREMATORY<br>BALTO. NATL. CEMETERY              |   |
|  |              |  |                             | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE MD.           |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 14 1965   |              | 25B. NAME OF REGISTRAR<br>Robert E. Staley   |                             | 25C. FUNERAL DIRECTOR ADDRESS<br>B. DABROWSKI 2818 E. BALTIMORE ST.      |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |                  |   |   |   |  |  |   |  |   |  |                             |  |  |
|--|--|------------------|---|---|---|--|--|---|--|---|--|-----------------------------|--|--|
| BIRTH NO. 65 3997  |  |                  |   |   | CERTIFICATE OF DEATH  |  |  |   |  | Registered No. 65 3997                    |  |                             |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) Mary E. Arnold  |  |                  |   |   | 2. DATE AND HOUR OF DEATH<br>April 10, 1965 7:15 P.M.   |  |  |   |  |   |  |                             |  |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>3311 Abell Avenue<br>Baltimore, Maryland 21218  |  |                  |   |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY 12-02<br>C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore 21218<br>D. STREET ADDRESS (If rural, give location)<br>3311 Abell Avenue |  |  |   |  |   |  |                             |  |  |
| 5. SEX<br>female   |  | 6. RACE<br>white |   | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (specify)<br>married |   | 8. DATE OF BIRTH<br>Sept. 15, 1882   |  | 9. AGE (In years lost birthday)<br>82   |  | If Under 1 Yr. Months Days                |  | If Under 24 Hrs. Hours Min. |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Packer  |  |                  |   | 10B. KIND OF BUSINESS OR INDUSTRY<br>Good Humor Company             |   | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland               |  |   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.    |  |                             |  |  |
| 13. FATHER'S NAME<br>Henry Ford  |  |                  |   |   | 14. MOTHER'S MAIDEN NAME<br>(unknown) Mary  |  |  |   |  |   |  |                             |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |  |                  |   | 16. SOCIAL SECURITY NO.<br>213-28-9210                              |   | 17. INFORMANT ADDRESS<br>Frederic W. Arnold, 3311 Abell Avenue, 21218          |  |   |  |   |  |                             |  |  |
| 18. 450.01<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |                  |   |   | CAUSE OF DEATH<br>(A) Generalized arteriosclerosis<br>DUE TO<br>(B)<br>DUE TO<br>(C)  |  |  |   |  | INTERVAL BETWEEN ONSET AND DEATH<br>Years |  |                             |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |  |                  |   |   |   |  |  |   |  |   |  |                             |  |  |
| 19A. DATE OF OPERATION   |  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   | 20A. AUTOPSY? (Yes or No)<br>No  |  |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |                             |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |   |   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)    |  |   |  |   |  |                             |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   |   | 21F. HOW DID INJURY OCCUR?   |  |   |  |   |  |                             |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from July 14 1962 to April 10 1962, that (I) (we) last saw the deceased alive on April 10 1962 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                   |  |                  |   |   |   |  |  |   |  |   |  |                             |  |  |
| 23A. SIGNATURE<br>Herman Brecher<br>M.D.   |  |                  |   |   |   |  |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |  | 23B. DATE SIGNED<br>April 12, 1964        |  |                             |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Herman Brecher   |  |                  | 23D. ADDRESS<br>M.D. 443 East 25th Street, Baltimore 21218, Md  |   |   |  |  |   |  |   |  |                             |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |  |                  | 24B. DATE<br>4-14-65  |   | 24C. NAME of CEMETERY or CREMATORY<br>Parkwood Cemetery   |  |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland  |  |   |  |                             |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 14 1965   |  |                  | 25B. NAME OF REGISTRAR<br>Robert E. ...   |   |   | 25C. FUNERAL DIRECTOR ADDRESS<br>Wm. Cook & Brooks, Inc., 1217 St. Paul Street |  |   |  |   |  |                             |  |  |



65 3998

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

Registered No.

65 3998

BIRTH NO.

M.E. CASE NO.

1. NAME OF DECEASED  
(Type or Print)

Clarissa Eubank

2. DATE AND HOUR OF DEATH

April 12, 1965

2:25 P.M.

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(If not in hospital or institution, give street  
address or location)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

C. CITY OR TOWN (If outside city limits, write RURAL and give township)

Baltimore

D. STREET ADDRESS (If rural, give location)

4315 Clareway

5. SEX

Female

6. RACE

White

7. MARRIED, NEVER MARRIED  
WIDOWED, DIVORCED (specify)

Divorced SINGLE

8. DATE OF BIRTH

1-31-25

9. AGE (In years  
last birthday)

40

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Waitress

10B. KIND OF BUSINESS OR INDUSTRY

Tavern

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

George David Webb

14. MOTHER'S MAIDEN NAME

Eleanor Brady

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.  
214-20-583217. INFORMANT  
Mrs. Catherine Long, 4118 Ardley Ave., Zone 18

ADDRESS

18. DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH  
(This does not mean the mode of dying, e.g.,  
heart failure, osthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) Laennec's Cirrhosis  
DUE TOINTERVAL BETWEEN  
ONSET AND DEATH

5 years

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(B)  
DUE TO

(C)

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

Yes

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

Yes

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

☐Not While  
At Work☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from March 5, 1965 to April 12, 1965,  
that (I) (we) lost saw the deceased alive on April 12, 1965 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M.D.

Attending  
Phys.Med.  
DirectorStaff  
Phys.

23B. DATE SIGNED

4-12-65

23C. PHYSICIAN'S  
NAME (Type)

Charles C. Carpenter M.D.

23D. ADDRESS

4940 Eastern Avenue 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)  
CREMATION

24B. DATE

4-14-65

24C. NAME of CEMETERY or CREMATORY

Green Mount Crematory

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

APR 14 1965

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

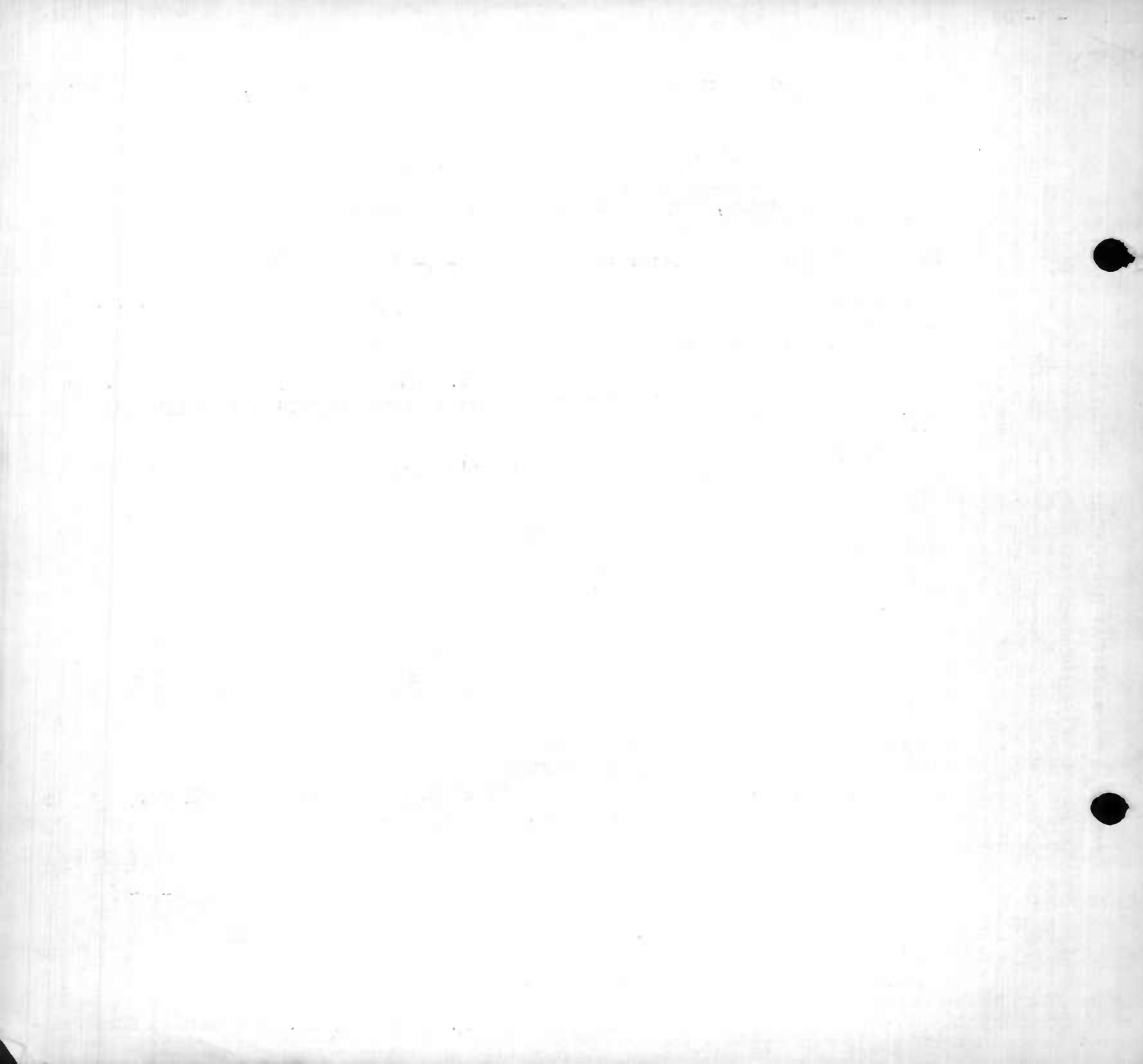
Hamilton

ADDRESS

Wm. Cook-Brook, Inc., 6009 Harford Road, 21214

FUNERAL DIRECTOR: IMPORTANT

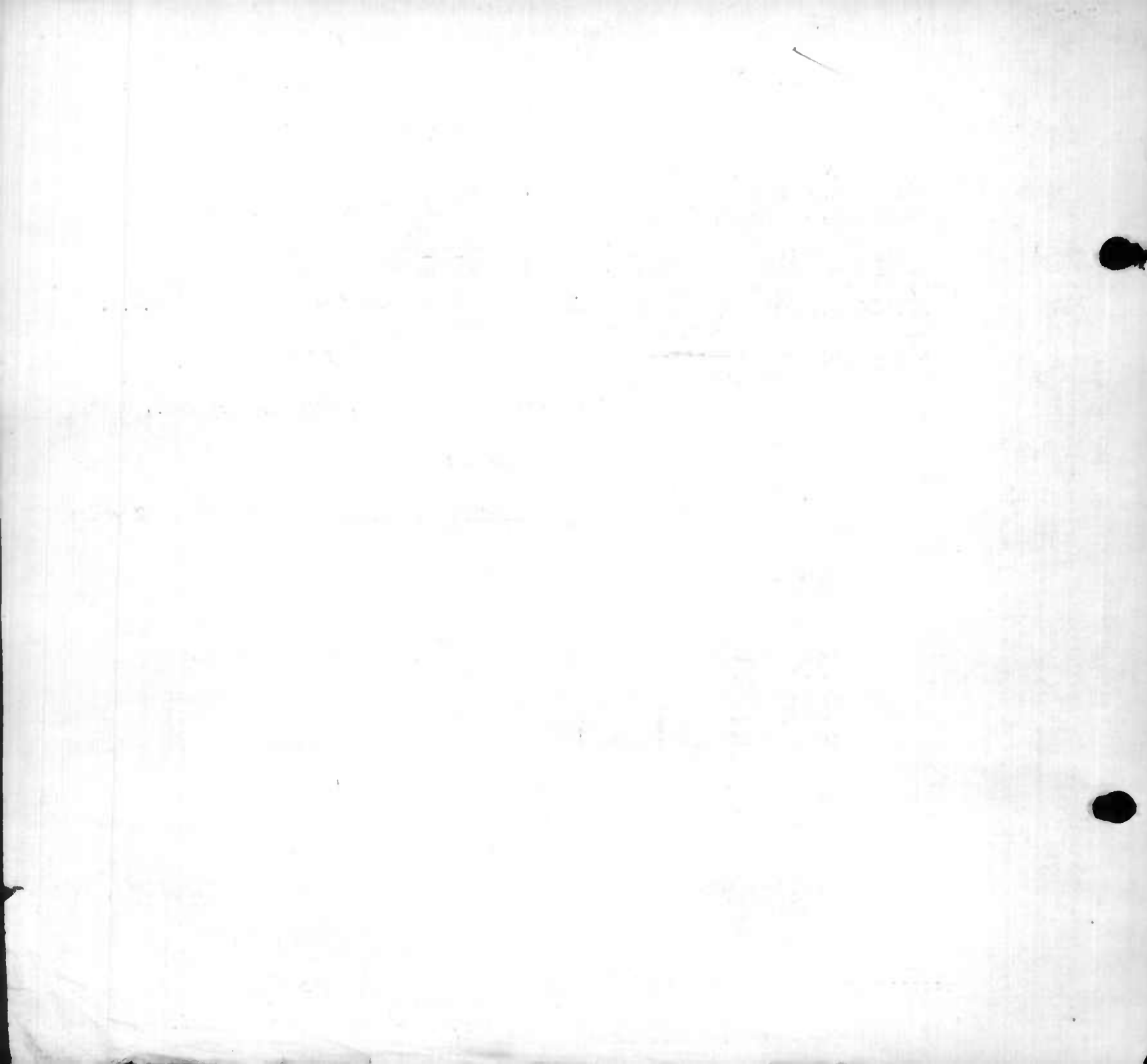
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |
|--|--|--|--|
| BIRTH NO.<br>65 3999   |  | 2. DATE AND HOUR OF DEATH<br>April 13, 1965 1:30 P.M.  |  |
| M.E. CASE NO.  |  | 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |  |
| 1. NAME OF DECEASED<br>(Type or Print) CLARA P. ROUSE  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland B. COUNTY Baltimore |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br>Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland, #21224  |  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Rural   |  |
| 5. SEX<br>Female   |  | 6. RACE<br>White   |  |
| 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br>Widow  |  | 8. DATE OF BIRTH<br>12-19-1891   |  |
| 9. AGE (In years last birthday)<br>73  |  | 10. AGE (In years last birthday)<br>73   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>NONE  |  |
| 11. BIRTHPLACE (State or foreign country)<br>North Carolina  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>Joseph A. BELCHER   |  | 14. MOTHER'S MAIDEN NAME<br>POTTER   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br>24234-2288  |  |
| 17. INFORMANT<br>RECORDS: BCH, 4940 Eastern Ave., #21224   |  | ADDRESS  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>Metastases   |  | INTERVAL BETWEEN ONSET AND DEATH<br>1 year   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Carcinoma of Stomach   |  | 2 years  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.<br>Emphysema  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)<br>No  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                       |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  |
| 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 2, 19 65 to April 13, 19 65, that (I) (we) last saw the deceased alive on April 13, 19 65 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |
| 23A. SIGNATURE<br>Howard Rathbun   |  | 23B. DATE SIGNED<br>APRIL 13, 1965   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>HOWARD RATHBUN   |  | 23D. ADDRESS<br>4940 Eastern Avenue, #21224  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>4-13-65   |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>WEST VIEW  |  | 24D. LOCATION<br>KINSTON NC  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 14 1965   |  | 25B. NAME OF REGISTRAR<br>F. Taylor  |  |
| 25C. FUNERAL DIRECTOR<br>Wm. Cook-Brooks, Inc., 1217 St. Paul Street   |  | ADDRESS  |  |





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |  |                             |  |  |
|--|------------------|--|-----------------------------|--|--|
| BIRTH NO. 65 4000  |                  | BALTIMORE CITY HEALTH DEPARTMENT   |                             | Registered No. 65 4000   |  |
| M.E. CASE NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print) Theodore Yowell   |                             | 2. DATE AND HOUR OF DEATH<br>14 April 1965 1:00 A.M.                         |  |
| 3. PLACE OF DEATH IN BALTIMORE, MARYLAND   |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |                             |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Johns Hopkins Hospital   |                  | A. STATE MD B. COUNTY Baltimore  |                             |  |  |
| (If not in hospital or institution, give street address or location)   |                  | C. CITY OR TOWN (If outside city limits, write RURAL and give township)<br>Baltimore   |                             |  |  |
|  |                  | D. STREET ADDRESS (If rural, give location)<br>821 Brunswick Rd  |                             |  |  |
| 5. SEX<br>Male   | 6. RACE<br>White | 7. MARRIED, NEVER MARRIED<br>WIDOWED, DIVORCED (Specify)<br>MARRIED  | 8. DATE OF BIRTH<br>8/28/13 | 9. AGE (In years last birthday)<br>51  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Maintenance Man   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Martin's  |                             | 11. BIRTHPLACE (State or foreign country)<br>Barbourville, Va                |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                  | 13. FATHER'S NAME<br>Borton Yowell   |                             | 14. MOTHER'S MAIDEN NAME<br>Jessie Rohr                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no   |                  | 16. SOCIAL SECURITY NO.<br>228-09-2408   |                             | 17. INFORMANT ADDRESS<br>Preddy Funeral Home, Gordonsville, Va               |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  | CAUSE OF DEATH<br>(A) DUE TO CARCINOMA of the larynx<br>(B) DUE TO<br>(C)  |                             | INTERVAL BETWEEN ONSET AND DEATH<br>Oct 1964                                 |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.   |                  |  |                             |  |  |
| 19A. DATE OF OPERATION<br>31 Dec 1964  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of larynx  |                             | 20A. AUTOPSY? (Yes or No)<br>No  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                             | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)     |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                            |                             | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from Dec 28 1964 to April 14 1965, that (I) (we) last saw the deceased alive on April 14 1965 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                  |                  |  |                             |  |  |
| 23A. SIGNATURE<br>Hugh S. Biller   |                  | M.D. Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |                             | 23B. DATE SIGNED<br>14 April 1965  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>DR. HUGH BILLER  |                  | 23D. ADDRESS<br>Johns Hopkins Hospital   |                             |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>REMOVAL  |                  | 24B. DATE<br>4-14-65   |                             | 24C. NAME OF CEMETERY or CREMATORY<br>Maplewood Cemetery                     |  |
| 24D. LOCATION<br>Barbourville, Orange Co., Va  |                  |  |                             |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>APR 14 1965   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor   |                             | 25C. FUNERAL DIRECTOR ADDRESS<br>Wm. Cook-Brooks, Inc., 1217 St. Paul Street |  |

